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NO. _____

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1982

U.S. Supreme Court, U.S.

FILED

AUG 30 1983

ALEXANDER L. STEVAS,
CLERK

HENRY G. STORRS, M.D., and
PETER S. ROSI, M.D.,
Petitioners,

v.

STATE MEDICAL BOARD and
ALASKA STATE DIVISION OF
OCCUPATIONAL LICENSING,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE
SUPREME COURT OF THE STATE OF ALASKA

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QUESTIONS PRESENTED

The petitioners present for review the questions inherent in the following contention:

The petitioners were denied due process of law by arbitrary and capricious actions by a state board against their licenses to practice medicine.

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I

STATEMENT OF JURISDICTION

The petitioners respectfully pray that a Writ of Certiorari issued to review the Judgments and Opinions of the Supreme Court of the State of Alaska filed in these matters.

The Alaska Supreme Court decided the Storrs case in an Opinion dated April 29, 1983, reported at 664 P.2d 547 (Alaska 1983). A Petition for Rehearing was timely filed and was denied by an Order dated June 2, 1983.

The Alaska Supreme Court decided the Rosi case in an Opinion dated June 10, 1983, reported at 665 P.2d 28 (Alaska 1983).

Copies of the Opinions in both cases and of the Order denying rehearing in Storrs are set forth in the appendix hereto.

This petition is being filed within ninety days of the denial of the timely Petition for Rehearing in Storrs and within ninety days of the decision in Rosi, as required by 28 USC 2101. This court's jurisdiction is invoked under 28 USC 1257(3).

II

QUESTION PRESENTED FOR REVIEW

The petitioners present for review the questions inherent in the following contention:

The petitioners were denied due process of law by arbitrary and capricious actions by a state board against their licenses to practice medicine.

III

CONSTITUTIONAL PROVISION APPLICABLE

The applicable portion of Amendment XIV, Section 1, to the United States Constitution provides:

... nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

It is the contention of the petitioners that their constitutionally protected vital privilege to practice their professions has been infringed by arbitrary and capricious actions of a state board, denying to them equal treatment to others similarly situated.

IV

STATEMENT OF THE CASE

A. Proceedings.

On September 26, 1979, the Director of the State of Alaska Division of Occupational Licensing filed with the State Medical Board an Accusation initiating Case No. ME-80-07, accusing Henry G. Storrs, physician and surgeon, of lacking sufficient knowledge and/or skills in

the fields of practice in which he engages to a degree likely to endanger the health of his patients, seeking to suspend, limit or revoke his license to practice medicine (Storrs CR 1-3). A similar Accusation was filed against Peter S. Rosi, M.D., on November 9, 1979, initiating Case No. ME-80-09 (Rosi CR 1-2). Both physicians filed Notices of Defense (Storrs CR 4; Rosi CR 3), and each case was designated to be heard by a hearing officer (Storrs CR 6; Rosi CR 4). After the Accusations were amended and supplemented (Storrs CR 7-10, 12-13, 14-21; Rosi CR 5-7), in the case of Dr. Storrs, an eight day hearing before a hearing officer commenced on August 25, 1980 (Storrs CR 52), and in the case of Dr. Rosi a one day hearing was held before a hearing officer on September 22, 1980 (Rosi RT 1). The hearing officer on Dr. Storrs' case submitted her proposed Memorandum Decision on December 19, 1980 (Storrs CR 52-81; Appendix E hereto). The hearing officer in Dr. Rosi's case submitted his proposed Memorandum Decision on January 28, 1980 (Rosi CR 85-96; Appendix F hereto).

The State Medical Board met in Juneau, Alaska to consider these matters on February 6

and 7, 1982 (Board RT 1).¹ Counsel for d both physicians requested the opportunity to present either written or oral argument to the Board prior to the Board considering whether or not to adopt the Decisions proposed by the hearing officers (Board RT 6, 12-16). The Board, however, considered the matters in executive session with the hearing officers available to assist and advise and counsel for Drs. Storrs and Rosi objected to this procedure (Board RT 10).

Dr. Partnow, the Board chairman, disqualified himself from participating in these cases and designated Mr. Gellert, a lay member of the Board, to act as chairman (Board RT 4). The Board which considered these cases then consisted of a pediatrician employed by the Public Health Service, a radiologist employed by a

¹ Several reporter's transcripts are utilized in these cases. In Dr. Storrs' case the transcript of the administrative hearing will be referred to as "Storrs RT"; and the transcripts of testimony submitted by deposition will be referred to by the name of the deponent. The same references will be made with respect to Dr. Rosi, except that portions of a trial transcript involving a criminal charge against Dr. Rosi, of which he was acquitted, were submitted to the hearing officer. References to that trial transcript will be made as "Rosi Trial RT." Both cases were heard at the same meeting of the State Medical Board, so references to the transcript of that proceeding will be made as "Board RT."

hospital, a board certified specialist in internal medicine, and two non-physicians who were public members of the Board (Board RT 20-21). The Board then considered the cases in executive session with the hearing officers (Board RT 22). When the Board resumed public session, one of the non-physician members, in each case, moved to accept the reports of the hearing officers as amended (Board RT 23, 26), and a roll call vote was taken in each case. The motion in each case was opposed by the board certified specialist in internal medicine, but the motions carried on the votes of the two non-physicians, the hospital employed radiologist, and the Public Health Service employed pediatrician (Board RT 29, 38-39).

The Board entered its Decision and Order revoking Dr. Storrs' license to practice medicine on February 6, 1981, staying the effective date to March 9, 1981 (Storrs CR 84-89). The Board entered its Decision and Order conditioning Dr. Rosi's license to practice medicine on February 7, 1981 (Rosi CR 100-102).

Timely notices of appeal were filed with the appropriate superior courts by Dr. Storrs on March 2, 1981 and by Dr. Rosi on March 3, 1981. On May 12, 1982, the Superior Court issued an Opinion affirming the Board action as to Dr. Storrs and entered Judgment on May 19, 1982 (Storrs CR 297-313; Appendix B hereto),

and Dr. Storrs appealed to the Supreme Court of Alaska on May 19, 1982 (Storrs CR 314). The Superior Court issued a Memorandum and Order affirming the Board action as to Dr. Rosi on July 27, 1982 (Appendix D hereto) and Dr. Rosi appealed to the Supreme Court of Alaska on August 23, 1982.

The Alaska Supreme Court issued its Opinion affirming as to Dr. Storrs on April 29, 1983 (Appendix B) and denied rehearing on June 2, 1983 (Appendix A). It issued its Opinion affirming as to Dr. Rosi on June 10, 1983 (Appendix C).

B. Evidence As To Dr. Storrs.

Dr. Storrs graduated cum laude from Amherst College and then obtained his degree of Doctor of Medicine from the University of Pennsylvania Medical School. He did his internship at Episcopal Hospital in Philadelphia, followed by a one year fellowship in pathology and anesthesiology at the University of Vermont Medical School, and then a four year residency in surgery at the Meyers Clinic, Philippi, West Virginia (Storrs RT 826). After completing the residency in 1952, Dr. Storrs commenced practicing medicine in Fairbanks, Alaska where he has remained until the present day (Storrs RT 826-8). At the time Dr. Storrs came to Fairbanks, only one other physician had completed a four year residency (Storrs RT 828).

In 1971, after a refresher course, Dr. Storrs completed a two part examination by the American Board of Abdominal Surgery and became certified by that Board (Storrs RT 830). Over the years, Dr. Storrs has diligently sought to keep up with current developments in medicine by attending the annual meeting of the American College of Surgeons, the Pan Pacific Surgical Meeting, meetings of the Alaska State Medical Association and its scientific programs, as well as of the Fairbanks Medical Association and other seminars and symposiums (Storrs RT 831-833). He also has taken correspondence courses sponsored by the American College of Surgeons for which he has obtained credit (Storrs RT 835-6). He subscribes to and reads numerous medical journals (Storrs RT 837).

His practice in general surgery has included orthopedic surgery, neurological surgery, some ear, nose and throat surgery and considerable traumatic and emergency surgery, some thoracic surgery, thyroid surgery and surgery on breasts (Storrs RT 839). From 1967 to 1977, Dr. Storrs maintained a card file in his clinic listing each surgical procedure by category, the list totaling 927 surgical procedures, mostly in the hospital (Storrs RT 892). Thus, for that ten year period, he averaged approximately 90 surgical procedures per year, and his practice prior to 1967 was similar, but

after 1977, he was deprived of hospital privileges which limited his surgical practice to minor procedures (Storrs RT 628, 643, 843).

Dr. Storrs generally has maintained good relationships with the nurses and others with whom he has worked (Storrs RT 844) and has been prompt and systematic in following up on his referrals to other physicians, communicating with other physicians about patients referred to him, and completing his patient records and reports (Storrs RT 639-646).

The administrative hearing involved five of Dr. Storrs' hospital cases between 1972 and 1977 which are mentioned in the Amended Accusation, the Supplemental Accusation, and discussed in the hearing officer's Proposed Memorandum Decision (Storrs CR 7-10, 12-13, 52-81). A summary of each of those cases was attached as an appendix to Dr. Storrs' brief filed with the Alaska Supreme Court, but there is no opportunity to present those summaries with this petition. However, the hearing officer's summaries are included in Appendix E. Counsel for Dr. Storrs urged the Alaska Supreme Court not to rely on the hearing officer's summaries of the cases, because she did not have a transcript available and the summaries are inadequate and inaccurate.

The hearing officer's Proposed Memorandum Decision, which was the only material before the State Medical Board, as the hearing had not

been transcribed at that time, completely omits what Dr. Storrs has always considered and urged to be the most important evidence presented at the hearing: That is, the expert opinions of other physicians as to whether Dr. Storrs' standards in medical practice fall below the norms and standards of the profession. During the testimony of the first witness at the administrative hearing, counsel for Dr. Storrs raised the objection that the expert opinions must relate to the standard of care among physicians dealing with similar cases (Storrs RT 117). Counsel for the agencies contended that the standard of care was "beside the point" (Storrs RT 118). The hearing officer left the issue to be decided "by the Supreme Court" (Storrs RT 118).

Although the agencies failed to present any evidence indicating Dr. Storrs' professional competence and skill in general fell below the norms of practice that are uniformly or widely recognized in the profession, Dr. Storrs presented a great deal of evidence that his skill and competence does not fall below those norms. Dr. Marrow testified that Dr. Storrs was "excellent" (Storrs RT 990), "one of the better surgeons in the community" (Storrs RT 991) "equally competent to the best medicine has" (Storrs RT 993), "that his surgical technique is excellent" (Storrs RT 993), that "he

is a totally competent individual" (Storrs RT 1020), and especially when it is considered that the average accuracy of the medical diagnosis is 65% to 75% (Storrs RT 1036). Dr. Kemp, a board certified general surgeon practicing in Kent, Washington, testified that Dr. Storrs' care was adequate and proper in the three cases of which he reviewed the records (Kemp 6), that there was no evidence that he was lacking in sufficient knowledge and skill in general surgery and family practice (Kemp 25, 26), that any errors in the three cases were shared by the other doctors who participated (Kemp 26, 27), and that there was insufficient basis on those cases for any accusation against Dr. Storrs (Kemp 40).

Dr. Weston testified that his review of the cases indicated that Dr. Storrs' handling of them was within the standard of practice (Storrs RT 902, 906), that Dr. Storrs' medical competence and skill is equal to the others in Fairbanks and that his "judgment is excellent" (Storrs RT 906), that "he is always on top of any medical subject" (Storrs RT 927), and that he is careful and exercises good medical judgment (Storrs RT 928). Dr. Bartko testified that upon reviewing the record of the five cases presented at the hearing, he saw nothing below the standard of practice in Alaska (Storrs RT 760-1). Dr. Whellan expressed the

opinion that Dr. Storrs "is totally competent to practice the type of medicine he practices" (Storrs RT 594), and that he exercises good judgment (Storrs RT 595). Nancy Gardella, an experienced medical technician and office manager, testified that Dr. Storrs is more prompt and systematic with medical records and reports than are many other doctors in her experience (Storrs RT 646).

Dr. Hess, a witness presented by the agencies, testified that he has consulted for Dr. Storrs on about a dozen cases and that the working relationship has been satisfactory and in only one case did he have any criticism as to Dr. Storrs not consulting soon enough (Storrs RT 486). Dr. Grauman, another witness presented by the agencies, testified that he has worked with Dr. Storrs on about ten cases and in his opinion Dr. Storrs "perhaps" lacks good medical judgment to the extent that it endangers his patients (Storrs RT 403). Dr. Doolittle, a highly respected internal medicine specialist and former chief of staff of the hospital in Fairbanks, who was presented as a witness by the agencies, indicated that he has worked with Dr. Storrs on hundreds of cases and he expressed strongly the opinion that Dr. Storrs "does not have a lack" of knowledge and skill to the extent that it endangers his patients (Storrs RT 282). His assessment of

Dr. Storrs' medical judgment is that it is average or slightly below (Storrs RT 267). None of the other expert witnesses were asked to express any opinion as to Dr. Storrs' general medical competence.

Since none of this general evidence appeared in the hearing officer's report (See, Appendix E) and the Board refused to hear any comments, evidence, or argument from Dr. Storrs or his attorney, the Board was ignorant of the foregoing expert opinions when it voted to revoke Dr. Storrs' license to practice medicine.

C. Evidence As To Dr. Rosi.

Dr. Rosi received his Bachelor of Arts degree from Swarthmore College in Pennsylvania in 1957, the degree of Doctor of Medicine from the University of Chicago in 1961, and he did a rotating internship at Henry Ford Hospital in 1961-1962 (Rosi Trial RT Rosi 1). After that, he did six years of residencies: six months in general pathology at the University of Cincinnati, then he transferred to Northwestern University School of Surgery for a general surgery residency and during his final year he was supervising chief resident of the Northwestern University School of Surgery (Rosi Trial RT Rosi 2-3). He was first licensed to practice medicine in 1962 (Rosi Trial RT Rosi 3).

In 1968, Dr. Rosi began working primarily on the problem of development and research in medical education and in health care delivery systems for the Industrial Engineering Department of Northwestern University as well as intermittent work in medical clinics (Rosi Trial RT Rosi 3). During 1970 to 1972, he was Director of the Experiment in Medical Education in Alaska, which was a consortium of approximately eight or ten medical schools which were establishing a pilot project in the formation of a rural de-centralized medical school in Alaska, which has not yet come to fruition (Rosi Trial RT Rosi 4). In 1972 he went into the private practice of family medicine and general surgery in Petersburg, Alaska and, after one year, he transferred his practice to Sitka, where he continued to practice until the time of the hearing. He was the holder of hospital privileges at Sitka Community Hospital (Rosi Trial RT Rosi 4).

Dr. Rosi became certified by the American Board of Surgeons in general surgery in December 1969 (Rosi Trial RT Rosi 4).

During his practice in Sitka, the majority of the deliveries of babies attended by Dr. Rosi were done at the Sitka Community Hospital, but after a homebirth team was trained, only about two-thirds of the births he attended were at the hospital (Rosi Trial RT Rosi 5).

Dr. Rosi comes from a family of physicians and was steeped in medical judgment as he grew up (Rosi RT 180). His father and an uncle on his father's side were surgeons and other uncles on both sides and his mother's father were also physicians. He was taken for hospital rounds and house calls by the time he was five or six years old and heavily exposed to questions of medical ethics and judgment. His whole family are professional persons, one of his brothers being a surgeon and two brothers being lawyers (Rosi RT Rosi 180-181).

In 1976, Dr. Rosi was approached and prevailed upon by several people to train them to constitute a team for attending the home delivery of infants (Rosi RT Rosi 184). Initially, Dr. Rosi's attitude was negative, but he investigated and found as he became more involved that home delivery has many advantages (Rosi RT Rosi 185). Consequently, he trained a team of people, some of them being registered nurses or persons otherwise employed in hospital nursing or obstetrics (Rosi RT Rosi 183). The persons who were present at the birth of Jacob Stednick, an infant who died shortly after birth, resulting in the Accusation against Dr. Rosi, were members of the homebirth team and had participated with Dr. Rosi in ten or fifteen births each, and had attended training sessions of one to two hours every week since

1976 (Rosi RT Rosi 184). Their standard of care for home deliveries was to meet or exceed the standard of care in the Sitka Community Hospital (Rosi RT Rosi 188).

The Amended Accusation is based on the birth of Jacob Stednick on May 31, 1979 in the home of his parents, attended by Dr. Rosi and the homebirth team he had trained (Rosi CR 5-7). The Accusation alleges that Dr. Rosi failed to take steps necessary adequately to treat the infant, who was born seriously ill, suffering from meconium aspiration syndrome, such failure including but not limited to Dr. Rosi's failure to hospitalize the infant until approximately eight hours following the delivery. The Accusation contends that various facilities and methods of treatment were available at the hospital which were not available at the infant's home. The infant died on the night of May 31, 1979 at the United States Public Health Service Hospital in Sitka. The Accusation alleges, "Respondent's medical performance in the above case indicates that he is professionally incompetent within the meaning of the definition in the statutory section and regulation and thereby providing grounds for Board action" (Rosi CR 6).

The same case was the basis of a charge in Case No. 1SI-79-456 Cr., charging Dr. Rosi with the crime of manslaughter, but in a Memorandum

of Decision on April 24, 1980, Judge Thomas E. Schulz found that Dr. Rosi's diagnosis was erroneous, but not the result of culpable negligence and directed the Clerk of Court to enter a verdict of not guilty (Rosi CR 33-40).

The principle evidence adverse to Dr. Rosi consisted of opinions of two physicians. One of those, Dr. Berner, received his M.D. from the University of Oklahoma School of Medicine in 1968 and for the six years preceding the trial had been chief of obstetrics at the Public Health Service Hospital in Sitka, carried on general family practice, and done some consulting in internal medicine and obstetrics in the community and he was certified by the American Board of Family Practice (Rosi Trial RT Berner 1-2). He stated that he had attended the delivery of between 1,800 and 2,000 infants (Rosi Trial RT Berner 2).

As his opinion of the quality of medical care tendered by Dr. Rosi in the Stednick case, Dr. Berner stated, "I think the care was terrible. It was grossly negligent" (Rosi Trial RT Berner 10). At the hearing, Dr. Berner expressed the opinion that Dr. Rosi lacks sufficient skills, knowlege, or medical judgment to a degree likely to endanger the health of his patients in the area of obstetrics (Rosi RT 44). Dr. Berner remained steadfast in these opinions despite it being pointed out to him

that at least four highly qualified experts who had testified disagreed with him (Rosi RT 140). However, Dr. Berner acknowledged that all physicians make errors in judgment (Rosi RT 176).

The other physician who testified against Dr. Rosi was Dr. Chiappinelli, also an employee of the Public Health Service at Sitka (Rosi Trial RT Chiappinelli 1). Dr. Chiappinelli graduated from Brown University in 1971 and the University of Vermont Medical School in 1975 and did a pediatric residency at Syracuse New York State Medical Center from 1975 to 1978 (Rosi Trial RT Chiappinelli 1). He had taken the written part of the Pediatrics Board exam and was scheduled to take the oral part in the fall of 1980 (Rosi Trial RT Chiappinelli 1). Dr. Chiappinelli expressed his opinion as to the care rendered by Dr. Rosi to the Stednick baby, "I would say that the care the baby received was obviously negligent - grossly negligent, if you will" (Rosi Trial RT Chiappinelli 43).

Opinions of four experts favorable to Dr. Rosi were presented. Dr. Babcock, a board certified specialist in obstetrics and gynecology who had practiced in Ketchikan, Alaska for nine years, had 24 years total experience in medicine, and had attended nearly 6,000 births (Rosi RT 288), stated he had had personal experience with Dr. Rosi since 1972 and Dr.

Rosi had referred approximately 70 patients to him, giving him the opportunity to examine Dr. Rosi's charts and records in those cases, and he also had reviewed the records on the Stednick case (Rosi RT 288-90). In Dr. Babcock's opinion, Dr. Rosi is not deficient in training or experience in the field of obstetrics (Rosi RT 292), and "his judgment has been very good" and he is a very careful practitioner (Rosi RT 293). Dr. Babcock's judgment differed from Dr. Rosi's on the particular case in question because he would have preferred to have transferred the baby to the hospital sooner (Rosi RT 302), but, nevertheless, he would without any hesitation continue to refer patients to Dr. Rosi, because none of his experience with Dr. Rosi nor the Stednick case would justify any limitation being placed on Dr. Rosi's practice or the placing of Dr. Rosi under supervision of another physician (Rosi RT 304). In Dr. Babcock's opinion, any error made by Dr. Rosi in the Stednick case was not of a magnitude that is uncommon in medical practice (Rosi RT 304). When asked if any such error by Dr. Rosi in that case was such a flagrant error as to warrant some action against Dr. Rosi's license, Dr. Babcock responded, "Of course not" (Rosi RT 312).

Dr. White, who has practiced medicine since 1943 and presided over approximately

3,500 births and been present at approximately 2,000 additional births and is President of the American College of Home Obstetrics (Rosi RT 314, 315, 333), had read the trial testimony of the other physicians and reviewed the records pertaining to the Stednick case (Rosi RT 316). He also had interviewed Dr. Rosi at length, seen his office and its facilities and visited the Sitka Community Hospital (Rosi RT 316). He expressed the opinion that there is no basis for the State's contention that Dr. Rosi should be limited in his practice of obstetrics and he stated, "If I had a pregnant daughter who was coming to Sitka and Dr. Rosi was going to stay here, I would ask her to see him" (Rosi RT 331). Dr. White could not see any basis for Dr. Berner's opinion that Dr. Rosi lacks either professional competence or judgment (Rosi RT 332). Dr. White pointed out that young physicians, such as Dr. Berner and his own two sons, frequently are hyper-critical of other people's bad results and after they get into trouble a little more themselves, Dr. White thinks they will learn to be more charitable and try to give a broader interpretation to the possibilities of a case (Rosi RT 334). Dr. White expressed the opinion that Dr. Rosi did not make any error in the Stednick case, that even if the worst of Dr. Berner's conjectures were correct, the incident was not of such magnitude

that any Board should try to limit Dr. Rosi's right to practice medicine based on that one case (Rosi RT 337-8).

Dr. Matviuw, who is board certified in obstetrics and gynecology since 1972 and practices exclusively in that field, is on the staff of Sherman Hospital and St. Joseph's Hospital, both in Elgin, Illinois (Rosi RT 65, 67). He has presided over the births of between 8,000 and 9,000 babies (Rosi RT 66). He had reviewed the prenatal record of Mrs. Stednick, the notes and records kept by Dr. Rosi and his team, and the hospital records, as well as the autopsy and the reports of interviews with Dr. Chiappinelli, and he also had discussed the case with Dr. Rosi in detail (Rosi RT 75). He found no evidence of negligence or questionable practice by Dr. Rosi in the therapy of Stednick infant and expressed the opinion that all of Dr. Rosi's actions were appropriate and consistent with his findings and observations during the course of therapy (Rosi RT 76). He thought it was incredible that Dr. Chiappinelli could draw the conclusions he did without at any time in detail discussing the course of events with Dr. Rosi and that his conclusions were not only unjustified but highly irresponsible (Rosi RT 77, 78).

Dr. Knudson, a neonatologist, who practices at Tacoma General Hospital and is on the

clinical faculty of the Department of Pediatrics at the University of Washington (Rosi Trial RT Knudson 2, 3) had read the transcripts and records pertaining to this matter up to the time of the trial and heard the testimony of Dr. Rosi and Dr. Babcock. He considered Dr. Rosi's failure to transport the infant to the hospital sooner was an error of judgment, but he characterized that error as similar in gravity to several such errors made by Dr. Chiappinelli when the infant was taken to the Mt. Edgecombe Hospital (Rosi Trial RT Knudson 4-14).

The hearing officer made no mention of the opinions of these four highly qualified experts in the field of medicine in his proposed Memorandum of Decision and gave no consideration to whether or not Dr. Rosi's knowledge and skill in the field of medicine measured up to the norms and standards of practice in the profession (Appendix F). The Opinion of the Superior Court judge affirming the Board's decision likewise omitted any mention of norms and standards of medical practice (Appendix D), as did the Opinion of the Alaska Supreme Court (Appendix C). Thus, although the heavy preponderance of expert opinion evidence indicates that Dr. Rosi is more competent and skilled than most other physicians, he has been singled out to have his professional standing and repu-

tation, and consequently his ability to earn a living, destroyed by conditions being imposed on his license to practice his profession.

V

ARUGMENT STATING REASONS
FOR GRANTING THE WRIT

This court has recognized that a licensed horse racing trainer has a property interest in his license sufficient to invoke the protection of the due process clause and the equal protection clause of the United States Constitution, Barry v. Barchi, 443 U.S. 55, 64, 99 S. Ct. 2642, 2649, 61 L. Ed. 2d 365 (1979). The due process clause applies also to deprivation of a driver's license by a State, Dixon v. Love, 431 U.S. 105, 112, 97 S. Ct. 1723, 1727, 52 L. Ed. 2d 172 (1977), and the Alaska Supreme Court has held that a hunting guide license is a sufficient property interest to qualify for protection of due process, Herscher v. State Dept. of Commerce, 568 P.2d 996, 1003 (Alaska 1977). Surely a physician's interest in his license to practice medicine is at least equally deserving as a horse racing trainer's license, or a driver's license or hunting guide's license to constitutional protection and to consideration by this court.

Due process precludes arbitrary impositions on protected interests, Ingraham v.

Wright, 430 U.S. 651, 678, 97 S. Ct. 1401, 1416, 51 L. Ed. 2d 711 (1977). When a governmental entity vested with broad administrative powers acts in an arbitrary manner so as to affect capriciously the property rights of persons subjected to its administrative controls, it has denied to those persons due process of law, Walsh v. Kirby, 529 P.2d 33, 42 (Cal. 1974), citing Davidson v. New Orleans, 96 U.S. 97 (1877) and Rudder v. United States, 226 F.2d 51, 53 (D.C. Cir., 1955). It is arbitrary and capricious for an agency not to take into account all relevant factors in making its determination, Citizens To Preserve Overton Park v. Volpe, 401 U.S. 402, 416, 91 S. Ct. 814, 823, 28 L. Ed. 2d 136, 153 (1971); Hanlay v. Mitchell, 460 F.2d 640, 646 (2nd Cir., 1972); State of Alaska, Department of Transportation and Public Facilities v. 0.644 Acres, More Or Less, 613 P.2d 829, 833 (Alaska 1980).

In these proceedings, the principal contention urged by Dr. Storrs and Dr. Rosi was that medical skill and competence is an art and, therefore, professional competence of an individual physician can be measured only on a relative basis, that is by comparing the performance of that physician with the norms and the standards ordinary in the practice. Thus, whether or not Dr. Rosi made an error in one case and Dr. Storrs made errors in five cases,

is of relatively minor significance in considering their professional competence, because all physicians make mistakes. Articles were cited including one published in the American Medical Association News, April 3, 1981, telling of a study made in two Boston teaching hospitals. One of the studies indicated that more than one of three patients admitted to a medical unit of a hospital had avoidable complications. The complications were life threatening or potentially disabling in one of ten patients. The second study said that surgical "misadventures" occurred in 1 of every 156 patients. More than half of the patients subjected to surgical misadventures died, and one third were released from the hospital with serious physical impairment. A study reported in the Journal of the American Medical Association, December 12, 1980 - Vol. 244, No. 23 at 2617, showed that 12.6% of all patients admitted to intensive care units in the hospitals studied were admitted due to iatrogenic (physician created) illness. Of these, 46.3% were admitted with iatrogenic diseases resulting from therapeutic or technical errors which were potentially avoidable. An article in Surgical Practice News, November 19, 1981, reports a study of 5,612 surgical patients admitted to Peter Bent Brigham Hospital (Boston) which showed a 1% incidence of serious iatro-

genic complications occurring on the general surgical service. A study reported in American Medical News, January 8, 1982, shows the average medication error rate in hospitals runs at approximately 12%.

The highly qualified medical experts who expressed opinions about the overall medical competence of Dr. Storrs were virtually unanimous that he is a highly skilled and excellent physician and surgeon. Of approximately 90 major surgical procedures a year over a long career performed by Dr. Storrs, the state agencies found only five cases upon which to attack him, thus indicating that his percentage of error appears to be far lower than the average of physicians. But none of this information was reported by the hearing officer to the State Medical Board (See, Appendix E) and the Board refused to hear any comments or arguments from Dr. Storrs or his counsel. Similarly, the Superior Court gave no consideration to what Dr. Storrs considered the most significant evidence in the case (See, Appendix to Supreme Court Opinion, included herein as Appendix B) and the Alaska Supreme Court also overlooked these vital and most relevant and important factors.

The same is true in Dr. Rosi's case. The hearing officer gave no consideration to Dr. Rosi's overall competence as compared with the

norms and standards in the profession and made no mention of the opinions in that regard expressed by the four highly skilled expert witnesses: Drs. Babcock, White, Matviuw, and Knudson (See, Appendix F). The Superior Court likewise refused to consider these most relevant factors (See, Appendix D). The Alaska Supreme Court did likewise (See, Appendix C).

Thus, in both cases, the action was entirely arbitrary and capricious because the most relevant factors were not taken into account and were withheld from the deciding Board. Of course, the members of the Board who adopted the hearing officer's decisions consisted of two non-physicians and two physicians who were not engaged in the private practice of medicine and the one voting member of the Board who was engaged in the private practice of medicine and had outstanding credentials opposed the motions in both cases.

Although the Alaska Supreme Court and the two Superior Court judges who decided these cases failed to consider the most relevant factors and, therefore, upheld the arbitrary and capricious agency actions, the highest courts of other states have recognized the principles which were urged by Dr. Storrs and Dr. Rosi. Therefore, the Alaska Supreme Court is in conflict with the highest courts of two other states.

In Megdal v. Oregon State Board of Dental Examiners, 605 P.2d 273 (Ore. 1980), the court recognized that terms which are analogous to "professional incompetence," may refer to norms of conduct that are uniformly or widely recognized in the particular profession, apart from the views of the agency itself, and in that sense would be external to the law, Id. at 278. Under such an approach, the Board's discretion is not without controls. The standards are those which are accepted by the practitioners in the community and must be ascertained through expert opinion, except where they are otherwise clear, Id. at 279. As indicated, the expert opinions elicited at the hearings, but withheld by the hearing officers from the Board, indicated that both Dr. Storrs and Dr. Rosi measured up to the standards accepted by other practitioners.

The same principles were recognized in Board of Dental Examiners v. Brown, 448 A. 2d 881 (Me. 1982), which is in sharp conflict with the opinions of the Alaska Supreme Court. Even the allegation in that case recognized the factors which Dr. Storrs and Dr. Rosi have always considered the most relevant, but which were not mentioned by the hearing officers, the Superior Court judges, and only tangentially in Footnote 1 of the Alaska Supreme Court's Opinion in Storrs (See, Appendix B). Although the

Alaska courts completely side-stepped the most vital issues, the Supreme Court of Maine did not, nor did the agency that advanced the initial charges in Board of Dental Examiners v. Brown, supra. That opinion states:

It alleged that he had failed to conform to the ordinary norms and standards of practice of orthodontics in his use -- or non-use -- of models, x-rays, diagnostic notes, treatment plans, patient history, and progress notes.

Id. at 882. That case did not deal with merely five cases; it dealt with treatment of five patients over long periods of time, ranging from five months to seven years, thereby constituting a sufficient range of evidence to determine some sort of pattern of practice, Id., which, of course, is entirely lacking in these cases.

The presiding judge in Brown set forth findings specifically dealing with the principles Dr. Storrs and Dr. Rosi have sought in vain to have considered with respect to them. There,

The presiding judge found that "defendant failed to exercise that degree of care and skill that a patient may reasonably expect from one licensed and holding himself out as a dentist limiting his practice to orthodontics," and that "defendant had failed to conform to the minimum standards acceptable and prevailing

in orthodontics practice and had thereby demonstrated incompetence and unskillfulness."

Id. The definition of incompetence in that case is what Dr. Storrs and Dr. Rosi consistently have sought to have applied:

In common parlance, "incompetence" means a lack of the learning or skill necessary to perform, day in and day out, the characteristic tasks of a given calling in at least a reasonably effective way. Competency does not mean perfection, and incompetence is not ordinarily established by the showing merely of an isolated instance in which performance has been inadequate. If, in view of the current state-of-the-art, a dentist's methods and techniques are sound, proof that his performance has been inadequate in rare and isolated instances during a long professional life, should not ordinarily subject him to revocation of his license ... for incompetence or unskillfulness."
...

[Incompetence] connotes a comparison, with due consideration of the state-of-the-art, between the performance of a dentist who is the subject of discipline ... and the minimally accepted level of performance, in similar circumstances, by American dentists generally. (Citations omitted).

Unlike the comparison that is made in an action for malpractice, the comparison is made for the purpose of

determining defendant's professional competence and skill in general, not merely his competence in treatment of one particular patient. (Emphasis added).

Id. at 883. This, of course, is precisely what Dr. Storrs and Dr. Rosi have urged from the inception, but their urging has been to deaf ears in Alaska. Clearly, however, their argument would have been recognized by the Supreme Courts of Maine and Oregon.

VI

CONCLUSION

The most important and relevant factors were not considered in the revoking of Dr. Storrs' license to practice medicine and the conditioning of Dr. Rosi's license to practice medicine. Thus, the actions taken were arbitrary and capricious, constituting denial of due process of law and equal protection of law.

The decisions of the Alaska Supreme Court upholding the administrative actions in these cases are in conflict with decisions of the highest courts of at least two other states in similar cases. For these reasons, it is urged that a Writ of Certiorari should be issued to review the Judgments and Opinions of the Alaska Supreme Court.

Respectfully submitted the 30 day of
August, 1983.


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Attorney for Petitioners,
Dr. Storrs and Dr. Rosi

IN THE
SUPREME COURT FOR THE STATE OF ALASKA

HENRY G. STORRS, M.D.,)	
)	
Appellant,)	
	)	ORDER
)	
	)	Supreme Court
STATE MEDICAL BOARD,)	
et al.,	)	No. 6882
)	
Appellees.)	
)	
)	

Before: Burke, Chief Justice, Rabinowitz,
Matthews and Compton, Justices, and Johnstone,
Superior Court Judge.

On consideration of the petition for re-
hearing filed May 16, 1983,

IT IS ORDERED:

The petition for rehearing is denied.

Entered by direction of the court at
Anchorage, Alaska on June 2, 1983.

CLERK OF THE
SUPREME COURT

/S/ Robert D. Bacon
ROBERT D. BACON

ccs: Justices Counsel

IN THE
SUPREME COURT FOR THE STATE OF ALASKA

HENRY G. STORRS, M.D.,)	
)	
Appellant,	)	File No. 6882
)	
v.	)	OPINION
)	
STATE MEDICAL BOARD and)	
ALASKA STATE DIVISION OF	)	No. 2661
OCCUPATIONAL LICENSING,)	
	)	April 29, 1983
Appellees.)	
)	
)	

Appeal from the Superior Court, State of
Alaska, Third Judicial District, Anchorage,
Brian Shortell, Judge.

Appearances: A. Lee Petersen, A. Lee Petersen,
Inc., Anchorage, for Appellant. Richard D.
Monkman, Assistant Attorney General, Anchorage
and Wilson L. Condon, Attorney General, Juneau,
for Appellees.

Before: Burke, Chief Justice, Rabinowitz,
Matthews, and Compton, Justices, and Johnstone,
Superior Court Judge.* [Connor, Justice, not
participating.]

PER CURIAM.

* Johnstone, Superior Court Judge, sitting
by assignment made pursuant to Article IV,
Section 16 of the Constitution of Alaska.

This is an appeal from a superior court order affirming a decision by the State Medical Board to revoke the license of Dr. Henry G. Storrs to practice medicine in Alaska on the grounds that Dr. Storrs was professionally incompetent.

The substantive issues raised by Dr. Storrs are as follows: (1) the combination of statutory and regulatory standards under which his license was revoked were unconstitutionally vague.¹ (2) the procedures followed by the

¹ The standards employed by the State Medical Board were those found in AS 08.64.330(b) and 12 AAC 40.970. AS 08.64.330(b) provides that:

After a hearing, a license may be suspended, limited, revoked or annulled, or the licensee may be reprimanded, censured or disciplined by the board for (1) unprofessional or dishonorable conduct as defined in AS 08.64.380-(3), (2) professional incompetence, or (3) a violation of this chapter or a regulation adopted under it.

12 AAC 40.970 (amended 1980, 1981) defined "professional incompetence" as follows:

As used in AS 08.64 and these regulations, "professional incompetence" means lacking sufficient knowledge or skills or both, in that field of practice in which the physician concerned engages, to a degree likely to endanger the health of his patients.

(Footnote 1 continued on next page)

State Medical Board were improper under AS 44.62.500, the provision in the Administrative Procedure Act which delineates the procedure to be followed in the resolution of contested cases;² (3) the Board's decision was not supported by substantial evidence.

Upon consideration, we reject Dr. Storrs' claims. Because we are in agreement with the reasoning of the superior court on each of the above questions, we adopt the court's opinion as the basis for our disposition of this appeal.

¹ Continued from previous page

Dr. Storrs contends that all doctors would be found incompetent under these standards, because all doctors have gaps in their knowledge, and this endangers their patients. In order to satisfy the requirements of due process, Storrs, a Fairbanks practitioner, claims that the level of his performance should have been measured against the standard of medical ability prevalent in Fairbanks and similar communities.

² Relevant portions of AS 44.62.500 are set out in the superior court decision which is attached, in slightly edited form, as an appendix to this decision. See infra, pp. 13-17, for provisions of AS 44.62.500 pertinent to this discussion.

Dr. Storrs' principal claim is that the standard of "professional incompetence" under which his license was revoked was unconstitutionally vague. In addition to the reasoning set forth by the superior court, we note that the recent United States Supreme Court decision of Village of Hoffman Estates Inc. v. Flipside, ____ U.S. ____, 71 L. Ed. 2d 362 (1982), has clarified the operation of the vagueness doctrine under the due process clause where the constitutionality of a civil statute or regulation is in question. Flipside establishes that civil laws must satisfy a minimum requirement of meaningfulness under the federal constitution, but that vagueness scrutiny is a flexible test to be adapted to fit the nature of the challenged regulation.

The degree of vagueness that the Constitution tolerates -- as well as the relative importance of fair notice and fair enforcement -- depend in part on the nature of the enactment ... The Court has ... expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe.

71 L. Ed. 2d at 371-72 (footnote omitted). We think that the reasoning of the superior court falls clearly within the dictates of Flipside.

Secondly, we note the recent decision by the Supreme Court of Maine in Board of Dental Examiners v. Brown, D.D.S., 448 A. 2d 881 (Me. 1982). In that case, a dentist's license was revoked under a statute that provided for such action in the case of proven "incompetence or unskillfulness." Id. at 882. Dr. Brown challenged the revocation on a theory quite similar to that relied upon by Dr. Storrs today:

He contends that the phrase "incompetence or unskillfulness" is so vague that no dentist can predict accurately whether his conduct falls within the purview of the disciplinary statute and that such vagueness permits ad hoc determinations uncontrolled by any regulatory standards.

Id. at 883.

The court rejected this contention, finding that the words "competence" and "skillfulness" were replete with meaning.

The expression "incompetence or unskillfulness" is not so uncertain in its meaning that further definitive rulemaking by the Board is required before a dentist may be disciplined It is sufficient to place a dentist on notice that if his professional performance does not remain at a minimally acceptable level of competence in the current state of the art, his license to practice may be revoked.

Understood in its ordinary meaning, the expression "incompetence or unskillfulness" provides an adequate guide for, and limitation on, the Board's exercise of authority and its range of discretion ... The plain intent of the statute is to permit the revocation or suspension of the licenses of incompetent dentists in the interest of public health and safety. Further legislative elaboration is not needed to ensure that the Administrative Court exercises its regulatory authority under this statute in accordance with a determination of policy made by the legislature or that it does not exercise unbridled discretion in carrying out the legislative mandate.

Id. at 884 (citations omitted). The persuasive reasoning of the Maine Supreme Court provides additional support for the result reached below in this case.

Attorney's Fees

We need not address Dr. Storrs' claim that he is entitled to an award of full attorney's

fees as a public interest litigant.³ Dr. Storrs plainly cannot be considered the prevailing party in this case, and he does not suggest that a losing party is entitled to a fee award under the public interest rule. No fees were assessed against Dr. Storrs by the superior court, and there is therefore no occasion to consider whether such an award was inappropriate.⁴

³ Dr. Storrs' claim notwithstanding, we note that there is no rule in Alaska law that a public interest litigant must be awarded full attorney's fees. We have held that private attorneys general should be awarded fees in conformity with the federal policy first articulated in Newman v. Piggie Park Enterprises, 390 U.S. 400, 19 L. Ed. 2d 1263 (1968) (per curiam). Anchorage v. McCabe, 568 P.2d 986, 990 (Alaska 1977). We have held that under McCabe, the trial court has "discretion to award full or only partial fees to public interest plaintiffs." Hutcherson v. State, 612 P.2d 1017, 1018 (Alaska 1980) (per curiam) (footnote omitted).

⁴ We have held on past occasions that it is an abuse of the trial court's discretion to assess attorney's fees against a litigant who in good faith has litigated issues of substantial public importance. Whitson v. Anchorage, 632 P.2d 232, 233-34 (Alaska 1981); Douglas v. Glacier State Telephone Co., 615 P.2d 580, 594 (Alaska 1980); Gilbert v. State, 526 P.2d 1131, 1136 (Alaska 1974).

Even if the posture of this case were such as to present Storrs' claim tht he is a public interest litigant, we would hold that Storrs' case was not a public interest lawsuit. We think that Dr. Storrs had a sufficiently strong private interest in challenging the Board's determination that he would have filed suit "even if [the action] involved only narrow issues lacking general importance." Kenai Lumber Co. v. LeResche, 646 P.2d 215, 223 (Alaska 1982). See Newman v. Piggie Park Enterprises, 390 U.S. 400, 402, 19 L. Ed. 2d 1263, 1265-66 (1968) (per curiam); F/V American Eagle v. State, 620 P.2d 657, 673-74 (Alaska 1980); appeal dismissed, ____ U.S. ____, 72 L. Ed. 2d 284 (1982); Anchorage v. McCabe, 568 P.2d 986, 990 (Alaska 1977).

The superior court's order affirming the State Medical Board's revocation of Dr. Henry G. Storrs' license to practice medicine is AFFIRMED.

APPENDIX OPINION OF THE SUPERIOR COURT
FOR THE STATE OF ALASKA,
THIRD JUDICIAL DISTRICT
(May 12, 1982) (Edited.)

Brian Shortell, Superior Court Judge.

This is an appeal from a decision and order of the State Medical Board dated February 6, 1981, revoking the license of Dr. Henry Storrs.

FACTUAL BACKGROUND

Dr. Henry G. Storrs is a physician licensed by the State of Alaska to practice medicine. On September 26, 1979, the State Division of Occupational Licensing filed an Accusation seeking to limit, suspend or revoke his medical license. The Division alleged that Dr. Storrs was professionally incompetent pursuant to AS 08.64.330(b)(2), and 12 AAC 40.970. The Division later filed amendments and supplemental accusations. Dr. Storrs filed his notice of defense on October 3, 1979.

The appointed hearing officer, Rebecca Snow, conducted an eight-day hearing in August 1980. Ms. Snow heard the testimony of twenty-four witnesses, seventeen of whom were physicians, and three of whom were nurses. In addition to oral testimony, 600 pages of hospital records were submitted as exhibits. On December 19, 1980, the hearing officer filed a

proposed decision with the State Medical Board, recommending revocation of Dr. Storrs' license to practice medicine. When the Medical Board met in a two-day session in February 1981, counsel for the State, Dr. Storrs, the hearing officer and Dr. Storrs' counsel were present. Before making its decision, the Board met for two hours in a closed session with the hearing officer present, accepted the proposed decision with some deletions, and entered a decision and order revoking Dr. Storrs' license.

ISSUES ON APPEAL

The appellant has raised the following five issues on appeal:

- I. AS 08.64.330(b)(2) and 12 AAC 40.970 are unconstitutionally vague and allow selective enforcement.
- II. The Board violated applicable statutory procedures.
- III. The Board's Decision is arbitrary and capricious and therefore lacks a reasonable basis.
- IV. The Board's findings are an abuse of discretion because they are not supported by substantial evidence.

I.

AMBIGUITY OF THE TERM "PROFESSIONAL INCOMPETENCE"

The appellant countends that the term "professional incompetence," as it is defined

in 12 AAC 40.970, is so ambiguous that it fails to give adequate notice of the conduct prohibited and therefore encourages arbitrary enforcement by the Medical Board.

While our Court has not yet addressed the constitutionality of the term "professional incompetence," a Colorado court has upheld an entire statutory provision that included this term. See, State Board of Dental Examiners v. Savelle, 8 P.2d 693 (Colo. 1932).

Most courts considering due process as it relates to licensing statutes and regulations have followed the reasoning of Connally v. General Construction Co., 269 U.S. 385, 70 L. Ed. 322 (1926), requiring that the statutory language be understandable to men of ordinary or common intelligence.

In testing the vagueness of a broadly drawn licensing statute, the court in Kansas State Board of Healing Arts v. Acker, 612 P.2d 610, 616 (Kan. 1980), applied a standard of "common understanding and practice." There the terms "immoral conduct" and "dishonorable conduct" were upheld against a due process attack.

The New York Court of Appeals has said, in considering a dentist's challenge to the statutory term "unprofessional conduct," that licensing regulations do not have to be so narrowly drawn that they actually "define with

particularity acts which would constitute unprofessional conduct." Bell v. Board of Regents, 65 N.E. 2d 184, 187 (N.Y. 1946). The court was of the opinion that the professional conduct demanded of practioners was not only embodied in their code of ethics but discernible to a "qualified person." Compare Pennsylvania State Board of Pharmacy v. Cohen, 292 A.2d 277 (Pa. 1972).

An Oregon court recently ruled that the term "unprofessional conduct" in a licensing statute was "constitutionally adequate as a directive giving the board authority to prescribe standards under which its licensees will be subject to professional discipline." Megdal v. Oregon State Board of Dental Examiners, 605 P.2d 273, 275 (Ore. 1980).

An issue in Cohen, supra, and Megdal, supra, was whether statutory language, similar to that challenged by Dr. Storrs here, gave the licensee, rather than the administrative agency, constitutionally adequate notice of proscribed conduct absent administrative regulations further specifying the prohibited acts. However, the statutory term "professional incompetence" (AS 08.64.330(b)(2)) at issue here has been further defined in the regulations governing the State Medical Board (12 AAC 40.970). Thus, the question posed is whether the term "professional incompetence," as it is

defined by the regulation, violates the constitutional due process guarantee.

The dictionary definition of the term "professional incompetence" is reasonably straightforward.¹ And, as further defined, the challenged term gives a physician adequate notice of the degrees of skill, knowledge, and competence which will be required of him. Twelve AAC 40.970 (amended 1980, 1981) provided:

"[P]rofessional incompetence" means lacking in sufficient knowledge or skills or both, in that field of practice in which the physician concerned engages, to a degree likely to endanger the health of his patients.

While "professional incompetence" is a broad term, it is not so vague that the administrative agency responsible for implementing the statute cannot formulate standards for professionals subject to its dictates. Read together, the statute and administrative regulation are not so ambiguously drawn that a qualified practitioner with ordinary intelligence

¹ Incompetent: "Without adequate ability, knowledge, fitness, etc.; failing to meet requirements; incapable; unskillful." Webster's New World Dictionary (2d College Edition).

and knowledge of professional ethics would be deprived of fair notice of the minimum standard of competence required.

When administrative regulations interpreting licensing statutes follow the general policy of the statutes, courts tend to uphold those regulations. See Megdal v. Oregon State Board of Dental Examiners, supra. Further, statutory construction adopted by those responsible for administering a statute should not be overruled in the absence of "weighty reasons." Kelly v. Zamarello, 486 P.2d 906 (Alaska 1971). See also, Whaley v. State, 438 P.2d 718 (Alaska 1968).

While the appellant contends that the allegedly vague language of the statute and regulation encourages selective and arbitrary enforcement by the Board, the evidence presented has not shown a history or pattern of arbitrary enforcement by the Board. See Summers v. Anchorage, 589 P.2d 863 (Alaska 1979). The Board in fact seems to have a minimal history of enforcement; the Storrs case is, apparently, the first time the Board has considered the revocation of a physician's license. In any event, the statute and regulation do not by reason of their language alone, show a danger of arbitrary enforcement; and, the fact that Storrs is the first physician whose license has been revoked does not,

without reliable evidence showing arbitrary or selective enforcement, establish a constitutional violation not demonstrated by the statutory language. That language is not unconstitutionally vague and it has not been shown to have resulted in selective and arbitrary action by the Board. Therefore, Dr. Storrs' contentions cannot prevail.

II.

VIOLATIONS OF APPLICABLE STATUTORY PROCEDURES

Dr. Storrs contends the Medical Board violated AS 44.62.500(b), by meeting with the hearing officer for two hours in closed session while the Board considered the proposed decision. He bases his argument on the silence of section 500(b) regarding the presence of the hearing officer, and on alleged significant changes in the decision made during the closed session.

AS 44.62.500(a), concerning contested cases heard before an agency, requires the hearing officer to be present when the agency considers its decision:

(a) If a contested case is heard before an agency (1) the hearing officer who presided at the hearing shall be present during the consideration of the case and, if requested, shall assist and advise the agency; and (2) a member of the

agency who has not heard the evidence may not vote on the decision.

AS 44.62.500(b), involving contested cases heard by the hearing officer alone, does not make the presence of the hearing officer mandatory, nor does it prohibit the hearing officer from being present:

(b) If a contested case is heard by a hearing officer alone, he shall prepare a proposed decision in a form which may be adopted as the decision in the case. A copy of the proposed decision shall be filed by the agency as a public record with the lieutenant governor and a copy of the proposed decision shall be served by the agency on each party in the case and his attorney. The agency itself may adopt the proposed decision in its entirety, or may reduce the proposed penalty and adopt the balance of the proposed decision.

Dr. Storrs interprets section 500(b)'s failure to require the presence of the hearing officer as equivalent to a command that the hearing officer shall not be present during consideration of the case when she alone has presided over the hearings.

The presence of the hearing officer at section 500(a) deliberations "to assist and advise" has been determined by the legislature to be mandatory to avoid possible procedural and substantive errors. However, the formalized procedures of section 500(b) are not

controlled by the previous section. In section 500(b) proceedings, the Board, which has not heard the evidence directly, has the advantage of a formal, written proposed decision for its consideration, one which has been at the Board members' and the parties' disposal prior to deliberations. The Storrs case is an example of a complex, formalized proceeding governed by section 500(b).

After extensive evidentiary proceedings presided over by the hearing officer, the thirty-page proposed decision in Dr. Storrs' case was filed December 19, 1980; the Board's decision was made on February 6, 1981. The parties and the Board had the proposed decision before the February 6 meeting. Dr. Storrs' counsel filed a ten-page memorandum dated one date prior to the meeting setting out his objections to the proposed decision, some of which were accepted by the Board.

In a less complex proceeding, the presence of a hearing officer to assist and advise an administrative agency should not always be required. Cases under consideration might be simpler; or the proposed decision might not refer to a voluminous evidentiary record. In Dr. Storrs' case, however, the proposed decision was long, technical, and complex; it had been submitted after extensive evidentiary proceedings which did not take place before the

Board; and there were objections from Dr. Storrs that the hearing officer's presence could have been a substantial factor in helping the Board to resolve. In such circumstances, the Board clearly felt the hearing officer should be present.

The absence of a mandatory phrase requiring the hearing officer's presence in section 500(b) deliberations cannot reasonably be interpreted to deprive the Board of the discretion to receive valuable assistance in a case such as this which so clearly required the hearing officer's assistance. The Board was not required to exclude her from its consideration of the proposed decision.

Dr. Storrs also contends the Board erred by refusing to allow him additional argument after it indicated what its decision would be. This argument is based on two assumptions: (1) The proposed decision was not "adopted" as that word is used in AS 44.62.500(c); and, therefore, (2) section 500(c) required the Board to provide "at a minimum ... either oral or written argument."

Appellant's contentions have no merit. The Board's February 6 decision "adopted with amendments" the proposed decision. The amendments made were minor, the most significant deletion being passages concerning the use and administration of the drug Mepergan. These

changes favored Dr. Storrs and they appear to have been made at the urging of his counsel; they cannot reasonably be construed as a failure of the Board to adopt the proposed decision. Thus, they did not bring section 500(c) into operation, and additional oral or written argument was not required. Additionally, the Board did give Dr. Storrs' counsel the opportunity to argue "on the amendments," which counsel declined to do, presumably because he wished instead to argue other matters. Additional argument under these circumstances was neither warranted nor required.

III.

STANDARD OF REVIEW

Initially, as to this portion of his attack on the Board's decision, Dr. Storrs contends that the Medical Board, composed of five physicians and two lay persons, lacks the expertise to decide thoroughly and fairly the issue of revocation of a doctor's license to practice medicine and asks the court to substitute its independent judgment for that of the Board.

Storrs further alleges that a lawyer is not capable of rendering a competent decision in the field of medicine. The hearing officer, a lawyer, heard the testimony of twenty-four witnesses, seventeen of whom were doctors, many of

whom practiced in Fairbanks, knew Dr. Storrs personally, and some of whom had worked with him on one or more of the cases in question.

Medicine is a complex subject and the State Medical Board is charged with the statutory authority and responsibility of regulating the practice of medicine. The Board is a competent body equipped with the necessary medical knowledge to determine whether a doctor's license to practice should be revoked. See AS 08.64.010; AS 44.62.340; AS 44.62.350; Kansas State Board of Healing Arts v. Foote, 436 P.2d 828, 834 (Kan. 1968). I see no justification for substitution of my independent judgment for that of the hearing officer, whose diligence and capability are demonstrated in this record, or the Board, a majority of whom are professionally trained in the field of medicine.

Secondarily, appellant argues for review under the "substantial evidence" test. See AS 44.62.570. Under this standard, the reviewing court does not reweigh the evidence or choose between competing inferences; it only determines whether such evidence exists. Interior Paint Co. v. Rodgers, 522 P.2d 164, 170 (Alaska 1974). Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Keiner v.

City of Anchorage, 378 P.2d 406, 411 (Alaska 1963).

The Board disagrees with Dr. Storrs as to the appropriate standard of review. It argues for application of the "reasonable basis" test. This test is used for the most part in cases concerning administrative expertise as to either complex subject matter or fundamental policy considerations; it is used to review agency action which is "essentially executive in nature." See Kelly v. Zamarello, supra. The reasonable basis test requires deference to be given to an administrative determination if it has a reasonable basis in law and fact. Alaska Public Utilities Commission v. Chugach Electric Association, 580 P.2d 687, 694 (Alaska 1978), overruled on other grounds, City and Borough of Juneau v. Thibodeau, 595 P.2d 626, 629 (Alaska 1979). The reasonable basis test permits the reviewing court to consider factors of agency expertise, policy, and efficiency in reviewing discretionary decision; it is similar to the standard of "unreasonable, arbitrary, and capricious action" under which actions committed to agency discretion are traditionally reviewed. Jager v. State, 537 P.2d 1100, 1107 (Alaska 1975).

It is not surprising that the parties cannot agree on the appropriate review standard. There would appear to be a similar dispute

among members of the Alaska Supreme Court. See State, Department of Labor v. Boucher, 581 P.2d 660 (Alaska 1978), in which the court split 3-2 on the question whether the Labor Department's conclusion that unemployment benefit applicants were "not available for suitable work" should be reviewed under the substantial evidence or reasonable basis test (final score: substantial evidence: 3, reasonable basis: 2).

Resolution of this question should depend on the nature of the administrative process under review. Dr. Storrs' revocation hearing was more like a judicial than an executive proceeding. It began with an accusatory pleading and continued along lines substantially similar to those in a contested court case. The ultimate decision depended primarily on findings of fact, which are traditionally reviewed by application of the substantial evidence test. Jager v. State, 537 P.2d at 1107. Although revocation proceedings of the Medical Board do involve "agency expertise" in the sense that the majority of the Board members are doctors who are appointed, presumably, for their expertise in the field, this expertise and the presence of complex medical subject matter does not automatically transform what is primarily a quasi-judicial proceeding into one in which considerations of "agency expertise, policy, and efficiency in reviewing discretionary

decisions" are fundamental. See Jager v. State, 537 P.2d at 1107.

I have concluded Storrs is correct in recommending the "substantial evidence" test. I have used this test in deciding this part of his appeal. A short summary of the evidence will be given in the next section of this opinion. This summary by no means approaches the detail with which the hearing officer listed the evidence in her findings; it is intended merely to describe major areas of the record which tend to support my conclusion that the record is adequate as a basis for the Board's conclusion that clear and convincing evidence was presented proving Dr. Storrs' professional incompetence.

IV.

SUBSTANTIAL EVIDENCE

Dr. Storrs' performance as a physician was evaluated according to the regulatory standard of 12 AAC 40.970. Under that standard, the evidence presented must show that as a medical practitioner, Dr. Storrs lacks "sufficient knowledge or skills or both, in that field of practice" in which he engaged "to a degree likely to endanger the health of his ... patients."

The hearing officer applied a "clear and convincing" standard of proof in evaluating the

evidence. Based on the nature of the proceedings and the reasoning of the Supreme Court in In Re Hanson, 532 P.2d 303 (Alaska 1975), the hearing officer decided that a high standard of proof was appropriate.

Hearing Officer Snow heard eight days of oral testimony from physicians familiar with Dr. Storrs. In addition, she read all the depositions published before and during the hearing and reviewed over 600 pages of hospital records. She specifically stated her reasons for not giving the testimony of certain expert witnesses the same weight as other doctors who showed a detailed knowledge of the facts and challenged medical procedures.

Based on the cumulative evidence presented, Hearing Officer Snow concluded that Dr. Storrs demonstrated a pattern of inadequacy which "greatly increased the exposure of his patients to risks of injury, pain and death." "The patterns of inadequacy and failure suggested by these cases include the inability to foresee and recognize common complications, the inability to recognize a need for a consultation regarding a developing complication, and the inability to identify and apply the most direct and appropriate diagnostic and corrective measures once a complication has developed."

Five of Dr. Storrs' cases were the primary focus of the evidentiary injury. These cases took place in the years 1972 to 1977.

In 1972, in a case in which a pregnant woman had a prolapsed umbilical cord which extended outside the vagina, Dr. Storrs attempted manual dilation of the patient's cervix, testified to by one witness as an "operation [which] has no place in modern obstetrics," "a deviation from accepted obstetrics procedure" and not really manual dilation, but "manual laceratin of the cervix." Testimony was presented that the procedure created a risk to the woman of an "incompetent cervix," not a risk to the baby being delivered, but a risk to the patient's next baby, were she to become pregnant again.

In the next case, a 1975 case involving a woman in childbirth who had a retained placenta, Dr. Storrs did not take steps to remove those portions of the placenta which had not been expelled or removed after the birth. Inordinate delay in removing a retained placenta, according to one physician practicing obstetrics and gynecology, involves a risk of infection and bleeding. In addition, Dr. Storrs did not call in a consultant. Although no serious consequences ensued, his actions in this case were deemed a "significant deviation from accepted practice."

Again, in 1975, Dr. Storrs treated a young woman for lacerations, abrasions, and a possible concussion received in a mini-bike accident. A Fairbanks plastic surgeon testified Storrs' work left dirt and foreign material in the patient's facial wounds which caused a "tattooing" effect which later required plastic surgery. This "tattooing," according to the witness, was caused by inadequate cleaning of the wounds. Again, according to the witness, there was no possible justification for the amount of foreign material left in the patient's wounds. The witness also testified to a personal experience in which Dr. Storrs had not accepted his offer to teach Storrs updated methods of burn care.

Once again in 1975, Dr. Storrs performed an intestinal bypass operation on a patient suffering from morbid obesity. His initial work-up on the case was described by an expert witness for the State as follows: "[I]n all my

years of practice I've never seen a more inadequate history or one that's shorter."² According to this witness, Dr. Storrs' mistakes in this case were "so all-embracing and so serious as to not constitute the ordinary run-of-the mill mistakes that every physician can and often does make." Also, this witness testified to Storrs' apparent reluctance to consult others. His testimony on this point was corroborated by other witnesses, who had personal knowledge of the procedures used in the bypass case, and of Storrs' reluctance to consult others. The bypass patient ultimately died.

² An indication of the hearing officer's objectivity and balanced approach to the evidence should be noted here. The passage quoted is very strong and might have been the basis for a finding that unequivocally condemned Storrs' work-up procedures in the bypass case. However, the finding does not concentrate solely on the quoted phrase. Instead, it reads as follows:

The record reflects limited testing work-up and no psychological examination in preparation for the operation. There is no indication that Respondent explained the extensive possible complications to the operation to the patient. However, at the time of this operation, ileojejunal bypasses were widely performed throughout the country without much more in the way of a work-up of the patient.

This type of careful comparison of evidence both favorable and unfavorable to Storrs is the rule, rather than the exception, in the hearing officer's decision.

The final case considered in depth was a liver biopsy performed in 1977. The hearing officer's conclusions can be summarized as stating that Dr. Storrs' procedures in this operation and its post-operative stages showed a lack of knowledge and skill about the procedure, failure to be aware of and deal with common post-operative complications, and inadequate response to the emergency situation which ultimately developed before the patient died. These conclusions are amply supported in the record.

The hearing officer filed almost thirty pages of detailed, accurate factual findings and balanced, thoughtful conclusions which are more than adequate to survive the substantial evidence test. As to the Board's ultimate decision to revoke Dr. Storrs' license, and the expertise of the Board members, on the basis of which Dr. Storrs apparently would have me either (1) substitute my judgment because of an inability to detect "the earmarks of thoroughness and fairness," or (2) reverse for failure of the record to establish a reasonable basis for the decision, or (3) reverse for lack of substantial evidence, I can only say that the record shows the procedures below were thorough, comprehensive and fair. The findings and conclusions are supported by substantial

evidence, and the decision clearly has a reasonable basis.

Dr. Storrs' appellate presentation is somewhat confusing in its melding of concepts of arbitrary and capricious action, reasonable basis, and substantial evidence. If he is arguing for reasonable basis review, it is clear the record meets this test as well as the substantial evidence standard, since the Board's procedures, findings, conclusions and ultimate decision have a reasonable basis in law and fact, and fall far short of being unreasonable, arbitrary and capricious. See Alaska Public Utilities Commission v. Chugach Electric Association, 580 P.2d 687, 694 (Alaska 1978); Jager v. State, 537 P.2d 1100, 1107 (Alaska 1975). If, on the other hand, Storrs' argument as to the reasonable basis of the Board's decision is merely an extension of his constitutional argument, that argument has been rejected in section I of this opinion.

CONCLUSION

After a review of the record and the briefs, and after oral argument in this case, I affirm the decision of the State Medical Board to revoke Dr. Storrs' license to practice medicine.

IN THE
SUPREME COURT OF THE STATE OF ALASKA

PETER S. ROSI, M.D.,)	
)	
Appellant,	)	File No. 7108
)	
v.	)	OPINION
STATE MEDICAL BOARD and)	
ALASKA STATE DIVISION OF	)	No. 2690
OCCUPATIONAL LICENSING,)	
	)	June 10, 1983
Appellees.)	
)	
)	

Appeal from the Superior Court, State of
Alaska, Third Judicial District, Sitka,
Thomas E. Schulz, Judge.

Appearances: A. Lee Petersen, A. Lee Petersen,
Inc., Anchorage, for Appellant. Richard D.
Monkman, Assistant Attorney General, Anchorage
and Norman C. Gorsuch, Attorney General,
Juneau, for Appellees.

Before: Burke, Chief Justice, Rabinowitz,
Matthews, and Compton, Justices, and Cutler,
Superior Court Judge.* [Connor, Justice, not
participating.]
PER CURIAM.

Cutler, Superior Court Judge, sitting by
assignment made pursuant to Article IV, Sec-
tion 16 of the Constitution of Alaska.

This appeal is taken from the superior court's affirmance of a decision by the State Medical Board placing certain conditions upon Dr. Peter S. Rosi's license to practice medicine on the grounds that Dr. Rosi was professionally incompetent.¹ Dr. Rosi's license was conditioned upon his seeking out further training during the year following the Board's order, and upon Dr. Rosi's submission of the records of all his obstetrical cases during

¹ The board's decision and order provided as follows:

IT IS THEREFORE ORDERED that Dr. Peter Rosi is allowed to hold his Alaska license to practice medicine but under two conditions.

1. It is a condition of his license to practice medicine in Alaska that he submit a plan for further training in neonatology to this board within six (6) months for approval. Dr. Rosi is to execute that plan within six (6) months of board approval of the plan.

2. Dr. Rosi is to submit all records of his obstetrical cases to a physician of his choice for a period of twelve (12) months beginning immediately. He shall submit the name and qualifications of the supervising physician to the board for approval. That physician shall submit quarterly reports to the board for up to one year, as determined by the board, informing the board that Dr. Rosi has or has not performed in a competent manner.

the next year to a physician of Dr. Rosi's choice, who in turn would inform the Board of Dr. Rosi's ongoing competence.

The board's decision to place conditions upon Dr. Rosi's license followed its determination that Dr. Rosi "committed a serious error in judgment" following the home birth of an infant, and that this error constituted "professional incompetence."

In brief, Dr. Rosi's error, as found by the board, was his failure immediately to hospitalize the newborn child, who was born seriously ill due to meconium aspiration.² Dr. Rosi delayed approximately six hours in getting the baby to the hospital, where the baby died.

In this appeal, Dr. Rosi advances four

² Meconium aspiration is the inhalation by a newborn infant of its own waste product.

specifications of error.³ We have concluded that resolution of this appeal is controlled

³ In his first two specifications of error Dr. Rosi asserts that the Board's decision is arbitrary and capricious, constituting an abuse of discretion as well as lacking any reasonable basis in law. Dr. Rosi's primary claim here is that the standard of "professional incompetence" set out in AS 08.64.330(b) and 12 AAC 40.970 is unconstitutionally vague and in actuality is no standard at all. In Storrs we rejected parallel arguments. See also Storrs v. Lutheran Hospitals, __ P.2d __, Op. No. 2650 (Alaska, April 1, 1983), where we concluded that there was no merit in the argument that it was a violation of a doctor's right to due process to suspend his hospital privileges based upon his gross negligence in a single case.

Dr. Rosi's third specification of error alleges that the Board violated AS 44.62.500(b) of the Administrative Procedure Act in allowing the hearing officer to be present during the Board's closed executive session. A similar argument was found lacking in merit in Storrs.

Dr. Rosi's fourth specification of error embodies his claim that he should be awarded full attorney's fees and costs since he is a public interest litigant. This same position was urged and rejected in Storrs.

by our recent decision in Storrs v. State Medical Board, _____ P.2d _____, Op. No. 2661 (Alaska, April 29, 1983). We therefore uphold the superior court's affirmance of the State Medical Board's decision in the case at bar for the reasons stated in Storrs.

AFFIRMED.⁴

⁴ Inherent in this opinion is the conclusion that there is a clear distinction between the standard of culpable negligence for criminal prosecutions under AS 11.15.080 and the licensure standard of professional incompetence. Also, there are differing burdens of proof in the two types of proceedings. Thus, Dr. Rosi's acquittal of a criminal charge of manslaughter is not determinative of the question of professional incompetence which is at issue here.

IN THE SUPERIOR COURT
FOR THE STATE OF ALASKA
FIRST JUDICIAL DISTRICT AT JUNEAU

PETER S. ROSI, M.D.)	
)	
Appellant,)	
	)	Case No.
v.)	
	)	JU81-324 Civ.
STATE MEDICAL BOARD,)	
and ALASKA STATE)	
DIVISION OF	)	MEMORANDUM
OCCUPATIONAL LICENSING,)	
	)	AND ORDER
Appellees.)	
<hr/>)	

This matter is before the court on appeal from a decision and order rendered by the State Medical Board placing Appellant Peter S. Rosi, M.D., on probation for a period of one (1) year. Appellant has challenged the action of the medical board on grounds that the hearing resulting in the decision and order of February 7 was an illegal hearing and that one member of the board was given no notice of the meeting and was absent. That matter was not briefed nor argued and the court considers it abandoned.

Appellant next contends that the board acted illegally because it did not adopt the recommendation of the hearing officer pursuant to AS 44.62.500(b) but instead met with the

hearing officer in executive session and adopted its own proposed decision without allowing argument as required by AS 44.62.500(b) for the reasons set forth in the appellees' brief. I disagree and affirm the action of the board in that regard, noting particularly that if one compares the hearing officer's memorandum of decision and recommended order with the amended order entered by the board it becomes immediately apparent that the board made no changes in the hearing officer's factual findings and instead simply substituted its own remedy for that proposed by the hearing officer. That action is well within the prerogative of the medical board.

Appellant next contends that the findings set forth by the hearing officer do not support the decision and order and that the findings set forth by the hearing officer as revised and amended by the board are not supported by the evidence: that some of the findings set forth by the hearing officer as revised and amended by the board were clearly erroneous; that there is no reasonable basis in law for the board's decision and order; that there is no reasonable basis in fact for the board's decision and order and that the board's decision is arbitrary and capricious. This court was the trial court in the criminal charge involving Dr. Rosi. I have reviewed carefully the transcript

from that trial that were made a part of the record on this administrative appeal as well as the transcript of the board hearing and I have reviewed the board's findings and decision and order under the substantial evidence test. Appellant first argues that one incident of negligence or mistaken judgment will not, as I understand it, support action on the doctor's license to practice medicine under any circumstances. It may well be that if more substantial action had been taken against Dr. Rosi's license, his argument may have some merit, but I reject the argument that only one incident of negligence or mistaken judgment will not suffice to support action by the medical board.

The record in this case amply demonstrates that the board was well aware of Dr. Rosi's generally fine reputation in the medical community and his past history as a competent physician, but concluded that the public interest in assuring reasonably competent physicians justified the one year probationary period conditioned on receipt of further training and supervision by another physician in his chosen specialty in this case and this court concludes that the board's decision was amply supported by the evidence and the law.

Finally appellant contends that the provision in AS 08.64.330(b)(2) and 12 AAC 40.970

pertaining to professional incompetence are void for vagueness and thus unconstitutional. After reviewing the authorities cited by the parties I am satisfied that the term professional incompetence has a well recognized meaning in the medical profession as it does in other professions, and certainly appellant cannot contend in this case that he was not fully aware of both the standard against which his conduct was to be measured and the specific conduct which was subject to scrutiny under the amended accusation filed by the Division of Occupational Licensing. For the reasons stated in appellees' brief I find for the board on the void for vagueness issue.

Because the court has sustained the decision and order of the State Medical Board, I need not reach the issue of appellant's attorney fees.

IT IS ORDERED that the decision and order of the State Medical Board be, and the same is, affirmed in all respects.

Dated this 22th day of July, 1982.

/S/ Thomas E. Schulz
THOMAS E. SCHULZ
Superior Court Judge

STATE OF ALASKA
DEPARTMENT OF COMMERCE
AND ECONOMIC DEVELOPMENT
BEFORE THE STATE MEDICAL BOARD

In the Matter of)	
Accusation against:)	
HENRY G. STORRS, M.D.	)	DECISION AND
Physician and Surgeon	)	ORDER
)	
Respondent	)	No. ME 80-07
)	
)	

On February 6, 1981, the State Medical Board, after having reviewed the Proposed Decision of Hearing Officer D. Rebecca Snow dated December 19, 1981, a copy of which is attached hereto, enters the following Decision and Order:

IT IS HEREBY ORDERED that the Proposed Decision dated December 19, 1981, is adopted with amendments indicated in the attachment as the Decision and Order of this board.

IT IS FURTHER ORDERED that the medical license issued to Henry G. Storrs is revoked.

The effective date of this Decision and Order is February 13, 1981.

DATED this 6th day of February, 1981, at
Juneau, Alaska.

STATE MEDICAL BOARD

/S/ Hubert J. Gellert
HUGH GELLERT,
Chairman

I hereby certify that 5 members of the
State Medical Board out of a total of 7 members
were present for the consideration of the above
entitled matter and that the vote in favor of
the above Decision and Order was 4 AYES and 1
NAYES with 2 members absent.

STATE MEDICAL BOARD

/S/ Hubert J. Gellert
HUGH GELLERT,
Chairman

STATE OF ALASKA
DEPARTMENT OF COMMERCE
AND ECONOMIC DEVELOPMENT
BEFORE THE STATE MEDICAL BOARD

In the Matter of:	)	PROPOSED
	)	MEMORANDUM
HENRY G. STORRS, M.D.	)	DECISION
)	
<hr/>	)	No. 80-07

This is a case brought by the Director of the Division of Occupational Licensing, Department of Commerce and Economic Development, State of Alaska, pursuant to AS 08.64.330, AS 08.64.325, and AS 44.62.330, to suspend, limit or revoke the license to practice medicine in the State of Alaska of Henry G. Storrs, M.D. (hereinafter "Respondent").

The State filed its Accusation with the Department of Commerce September 26, 1979, and Respondent filed his Notice of Defense on October 3, 1979. Thereafter the State filed an Amended Accusation with the hearing officer on March 17, 1980, a Supplemental Accusation on June 24, 1980, and a Second Supplemental Accusation on August 15, 1980.

The State has alleged in its pleadings that Respondent is disqualified from practicing medicine in the State of Alaska by reason of unprofessional conduct as defined in AS 08.64.380(3) and by reason of professional

incompetence, AS 08.64.330(b). The allegation of unprofessional conduct is based upon an alleged violation of Section 4 of the Principles of Medical Ethics of the American Medical Association, more specifically an allegation that Respondent failed to "accept [the profession's] self-imposed disciplines." The allegation of professional incompetence is based upon Respondent's conduct in the treatment of five separate patients from 1972 to 1977, which allegedly reveal not only specific errors but also deficiencies in practice and judgment that pervade Respondent's professional actions.

Evidence Considered

The hearing in this matter opened on August 25, 1980, presided over by D. Rebecca Snow, Hearing Officer. The State was represented by Amy Stephson. The Respondent was present throughout with his attorney, A. Lee Petersen. The hearing officer heard the oral testimony of Dr. John Miley, Dr. William Doolittle, Mr. Alvin Finneseth, Dr. William Wennen, Dr. David Grauman, Dr. Richard Hess, Dr. James Borden, Dr. William Montano, Dr. F. J. Whelan, Mrs. Nancy Gardella, Dr. Glen Straatsma, Mr. Johnny Byasseo, Dr. Joseph Worrall, Dr. Harold Bartko, Dr. Henry Storrs, Dr. Wayne Meyers, Dr. John Weston, Dr. Charles Marrow, Dr. Jeffrey Partnow, and Dr. George Murphy. The testimony of Dr. Aaron Kemp was

presented by publication of his deposition, and the testimony of Linda Luttrell, R.N., and Ann Tuttle, R.N., by video deposition. The hearing officer has read the transcripts of each of these depositions, as well as the depositions of Ethel Ghezzi, R.N., Dr. Jeffrey Partnow, Dr. Henry Storrs, and Dr. Harold Bartko that were published during the hearing. The hearing officer has thoroughly reviewed State's Exhibits A-M and Respondent's Exhibits 1-6.

The hearing officer's findings of fact and conclusions of law are based on all the evidence presented. However, the hearing officer found the evidence of Dr. John Weston and Dr. Harold Bartko to be of substantially less weight than that of the other doctors who testified.

Dr. Weston's testimony as to his qualifications revealed no specialized training under expert supervision in surgery or any other recognized medical specialty, although he has been in practice in Fairbanks for over thirty years. Most of his answers were too generalized to be of much help. His testimony revealed little familiarity with the details of any of the cases in question and no particularly thorough understanding of the complications actually experienced in these cases. This is consistent with his practice of relying heavily, by referral or consultation, on the

many specialists now available in Fairbanks. Dr. Weston did not have particularized knowledge about Respondent's training or updating of his skills.

Dr. Bartko has had several surgical residencies but, at the time he testified, had been denied surgical privileges at all hospitals in the vicinity in which he practices. Although he has taken the surgical certification examinations eight times, he has never passed them. He does not perform in his practice percutaneous liver biopsies or ileojejunum bypasses. His testimony on the other cases reviewed did not offer sufficient detail to add materially to the explication of the facts in any of them. Nor did it reveal the breadth and thoroughness of medical knowledge and understanding of such facts that was to be found in the testimony of most of the other doctors when they were testifying in their areas of specialty of training and practice.

The testimony of other doctors, who did not have firsthand knowledge of the individual cases either, was often of limited value also. Testifying to generalized conclusions without dealing with the specific medical facts of a particular case did not assist in the evaluation of the treatment given by Respondent. The hearing officer was more influenced by evidence of thorough understanding and analysis of the

actual medical situations than by sheer numbers of doctors taking any particular position.

For definition of specific medical terms not defined in testimony, the hearing officer relied on Stedman's Medical Dictionary, (14th Unabridged Lawyer's Ed. 1976).

Finally, the hearing officer recognizes that the practice of medicine is not an exact science, but one in which the state of the art evolves based on continually accumulating knowledge and experience. This quality necessarily creates situations in which practice and opinions will differ from doctor to doctor. The question thus becomes not whether anyone disagrees with Respondent's treatment of his patients, but whether such treatment falls outside the statutorily defined range of permissible differences in practice.

Grounds for Licensure Action
and Standard of Proof

The State has relied on two of the available statutory grounds for license revocation or other licensure actions. The first is "professional incompetence." AS 08.64.330(b). By regulation the term "professional incompetence" is further defined as meaning "lacking in sufficient knowledge or skills, or both, in that field of practice in which the physician concerned engages, to a degree likely to endanger the health of his patients." 12 AAC

40.150. There are no additional sources with which to further the interpretation of any of these terms, as the Supreme Court of the State of Alaska has not spoken on this issue. Further, the term "professional incompetence" is only one of many terms used by the other 49 states in their suspension and revocation statutes. As a result, the case law on suspension and revocation of medical licenses is not broadly applicable and therefore not helpful in this situation. See, Forgotson, Roemer and Newman, "Licensure of Physicians," 1967 Wash. U.L.Q. 249, 280-87; 61 Am. Jur. 2d, Physicians and Surgeons §62 (1972); see generally Annot., 28 A.L.R. 3d 487 (1969). The fact that the State Medical Board has defined with considerable specificity in regulation what is meant by "professional incompetence" makes a discussion of other terms used in other statutes or in other types of cases involving physicians unnecessary. Terms such as "gross carelessness," "manifest incapacity," "malpractice," "negligence" and "gross negligence" are in no way involved in the definition of grounds for licensure action applicable in the instant case.

The definition can be broken down into three operative parts. The first is "that field of practice in which the physician concerned engages." Respondent describes his

practice as a modified general surgical practice, which has included obstetrical and gynecological work and emergency room services. All of the cases presented at the hearing appear to fall within the Respondent's description of his own practice. The next important consideration is whether Respondent is "lacking in sufficient knowledge and skills, or both." "Knowledge or skills" must, in the medical context, be taken to include the exercise of judgment in the application of either. The final concern which must be applied to the evidence is whether any indication of lack of knowledge or skills or judgment is of such a degree that it is "likely to endanger the health of his or her patients." The question is not one of certainty, but of likelihood. "Endanger" is defined as "to bring into [exposure or liability to injury, pain or loss] or peril." Webster's New Collegiate Dictionary 375, 287 (1977 ed.). The evidence presented in this case has been carefully considered against these criteria.

The second alleged ground for revocation in this case is "unprofessional conduct." As a preliminary matter, Respondent has moved to strike the Second Supplemental Accusation due to untimeliness, based on the fact that the Second Supplemental Accusation was filed with the State's Pre-Hearing Memorandum on August

15, 1980, only ten days before the hearing was scheduled to begin. The State is plainly permitted by statute to file an amended or supplemental accusation at any time before the matter is submitted for decision. AS 44.62.400. The only requirement following such a filing, if it be late in the pre-hearing discovery process, is that Respondent have adequate opportunity to prepare his defense and to present it at the time of hearing or at such subsequent time as may be appropriate. In this case, the Respondent had been put on notice that his conduct in scheduling an ileojejunal bypass in 1976 was being considered by the State as part of its grounds for seeking to revoke his license. The only new information set forward by the Second Supplemental Accusation was the allegation that this conduct was not only "professional incompetence," but was also "unprofessional conduct," under the Principles of Medical Ethics of the American Medical Association. In the course of the hearing the State presented its evidence on the facts of the alleged violation and Respondent had an adequate opportunity to rebut those facts. Both sides also had adequate opportunity to argue the relevance or interpretation of the facts orally, as well as in written memoranda, to the Hearing Officer. There has been no violation of Respondent's due process rights

in the filing and consideration of the Second Supplemental Accusation.

A more basic issue is what definition of "unprofessional conduct" is to be applied in this case. The definition cited by the State in its Second Supplemental Accusation was from a portion of AS 08.64.380(3) which was revised by the Legislature in 1978. However, Respondent now concedes that AS 01.10.100(a) applies to the alleged violation in this case. As a result, the definition of "unprofessional conduct" found in AS 08.64.380(3)(G) "shall be treated as remaining in force for the purpose of sustaining any proper action or prosecution for the enforcement of the right, penalty, forfeiture or liability [incurred ... or accrued under such law]." AS 01.10.100(a) Respondent's Motion to Strike the Second Supplemental Accusation is hereby denied.

The definition of "unprofessional conduct," applicable to Respondent's conduct in this hearing, is "violating the principles of medical ethics of the American Medical Association and of the Alaska State Medical Association." AS 08.64.380(3)(G). The State is relying on a document entitled "Principles of Medical Ethics," which was adopted by the American Medical Association in 1957. (See attachment to Second Supplemental Accusation) The State specifically cites Section 4:

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

It is the State's position that the ban adopted by the staff at the Fairbanks Memorial Hospital on certain abdominal surgery which Respondent had practiced constitutes the above-referenced "self-imposed discipline." The evidence has been carefully considered for its proof of whether the ban was indeed a self-imposed discipline and whether the Respondent did fail to accept that discipline.

The question of the standard of proof required is another question on which this is a case of first impression in the State of Alaska. The only cases in Alaska which might offer some guidance on the appropriate standard of proof are cases involving the discipline of legal practitioners. In Re Hanson, 532 P.2d 303 (Alaska 1975), involved review of a proceeding by the Judicial Qualifications Commission against a judge. In that case, the Supreme Court adopted the standard of clear and convincing evidence as applicable in such proceedings because of the character of the

proceedings before the Commission and because of the nature of the public office involved. Matter of Robson, 575 P.2d 771 (Alaska 1978), involved a disciplinary proceeding before the Bar Association conducted under Bar rules which established the standard of proof as the "preponderance of the evidence" standard. Robson can be distinguished from Hanson in that there was a pre-established rule which set forth the standard of proof. It can also be distinguished on the basis of the type of proceeding involved and the type of discipline that could be imposed.

The instant case is more like Robson in the type of proceeding involved and in the type of discipline that may be imposed, and in the nature of the Respondent's position as a professional. At the same time, there is no pre-established regulation which sets forth the standard of proof applicable in a medical licensure hearing.

The legal disciplinary cases are almost equally divided in their use of the "preponderance of the evidence" standard of proof, the "clear preponderance" standard, and the "clear and convincing" standard. Annot., 105 A.L.R. 984 (1936). None of the jurisdictions cited uses the criminal standard of proof, i.e., "beyond a reasonable doubt." The jurisdictions that use the standards which are stricter than

the general civil standard of proof do so on a theory that the disciplinary proceedings before them are quasi-criminal in nature and involve a significant penalty in the restriction or prohibition of the accused's practice of his livelihood. This theory seems equally applicable to the situation of disciplinary proceedings against persons licensed to practice medicine.

Therefore, the standard of proof which has been applied to the evidence in the instant case is that it provide clear and convincing evidence of the stated elements which make up the alleged grounds for licensure action against Respondent.

PROFESSIONAL INCOMPETENCE

A. Patient No. 015-309 (1972)

Prolapsed Cord.

When this patient first came under Respondent's care, she was pregnant and had suffered the breaking of her bag of waters at the Fairbanks International Airport. On the way to the hospital, the ambulance was in an accident in which her spine was fractured. The patient was, according to her history, in the fifth month of her pregnancy. At the time she was admitted to the hospital, the fetus had not reached a state of development at which it could have been expected to live had it been delivered immediately. Respondent's initial

treatment of this patient was designed to retard or discourage labor, in the hopes that the infant would be allowed several more weeks to develop before being delivered and would thus have some change of survival following delivery. Respondent did not ask for or obtain a consultation with an obstetrician when this patient was first admitted to the hospital.

Eight days after the patient was admitted to the hospital, the umbilical cord protruded through the cervix (a prolapsed cord) and extended outside the vagina. The danger from a prolapsed cord is that the supply of nutrients to the fetus will be cut off. At this point in the development of this fetus, there was no possibility of saving the child because it still had not reached 26 weeks of development, and pediatric care for premature babies was not sufficiently advanced in Fairbanks in 1972 to give any hope of survival to a fetus as small as this one. (Dr. Hess, Dr. Worrall) Respondent's decision not to take the added risk to the patient of a Caesarean section was, therefore, a correct decision.

Still, the patient's need to deliver the fetus, while not an emergency, did need to be addressed promptly. The appropriate first step in response to this need would have been to attempt to induce labor by administering Pitocin for some period of time, as Dr. Worrall

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ordered when Respondent did ask him to consult some three and one-half hours after Respondent arrived at the hospital. Instead, Respondent attempted to assist the delivery with his hands and with sponge forceps, apparently intending to dilate the cervix sufficiently for the fetus to come through.

The fetus was in a breech position and, after approximately one hour and 40 minutes of effort, only the lower half of the body came through the cervix. After the lower extremities of the fetus were delivered, the upper half remained caught in the cervix. Respondent tugged forcefully on the infant's body for some 15 or 20 minutes in an attempt to dislodge the whole body. (Depo. Ann Tuttle, p. 13-14; Exhibit C, p. 17) When these efforts proved futile, the patient was returned to the labor room on Dr. Worrall's advice to try Pitocin. (Exhibit C, pp. 8, 20)¹ In the course

¹ There is no evidence in the hospital records or Respondent's testimony of any consideration given to the emotional trauma likely to be suffered by a woman who not only had suffered the death of the infant she was carrying, but then had to wait for over 18 hours with the remainder of the fetal body trapped in her cervix.

of the Respondent's delivery efforts, some damage was done to the cervix, according to the operation record he prepared following his dilation and curettage the next day. He indicated in his record "a small incision in the cervix to the left vaginal wall." Respondent in his testimony stated that it could have been a laceration. Dr. Hess testified that ~~*(the operation record description indicated a significant--injury--to--the--cervix)*~~. Such injuries are likely in any attempt to dilate the cervix, regardless of the instrument used. Any such injury to the cervix, if not repaired, could leave the patient with "an incompetent cervix," which could complicate future pregnancies. (Dr. Hess) ** The operation record did indicate a significant injury to the cervix. (Worrall) There is no indication in Respondent's operation record that this injury was

* Line 6, lined through, is deleted.

** Line 10, where underlined, is added, ending on Line 11.

tion record that this injury was repaired. (Exhibit C, p. 20) Respondent has no independent recollection of a repair.

During the two hours Respondent attempted to deliver the child, the patient was in extreme pain and eventually fainted. (Depo. Ann Tuttle, p. 11) Before beginning his efforts, Respondent administered only a pudendal block, which is a local anesthetic not effective in the general cervical area. Respondent's notes made after the procedure indicate that he have a paracervical block as well, but this is contradicted by the clear recollection of the nurse who was assisting him on this case in the delivery room. (Exhibit C., p. 26; Depo. Ann Tuttle, pp. 8-11) After almost an hour of effort toward delivery, Respondent permitted only one cc. of Mepergan to be given to the patient.

Respondent asserts his delay in the administration of pain medication was based on his desire not to run the risk of harming the fetus by use of a medication that would pass to the fetus through the mother's system. Respondent had already decided, in his decision not to do a Caesarean section, that in the balancing of the risks to the mother and the risks to the unviable fetus, protection of the mother was of more concern. Failure to mitigate the mother's pain was, therefore, either carelessness or

evidence of vacillation or lack of confidence in his own decision. * Moreover, Respondent's assertion of concern for the fetus at the point for the fetus at the point when it was clear that it could not be saved is inconsistent with his administration of Mepergan to this patient for the eight days preceding the delivery. The literature which accompanies the drug specifically indicates that it should not be used by pregnant women prior to the labor period "because safe use in pregnancy prior to labor has not been established relative to possible adverse effects on fetal development." (Exhibit M) Use of Mepergan during labor is also inconsistent with Respondent's assertion that he had some hope of saving the fetus, since the literature states "[w]hen used as an obstetrical analgesic, meperidine crosses the placental barrier and can produce respiratory depression in the newborn..."

* Line 2 through 12, where lined through, is deleted.

Conclusions

~~** Respondent's use of Mepergan for this patient for the eight days of hospitalization before the cord prolapsed exposed the life of the fetus to risks of unknown dimensions, without any indication in the record of expected benefits to the mother which were otherwise unobtainable and which outweighed the level of risk to the fetus.~~

Respondent's failure to use pain medication during the initial efforts to deliver the fetus was not justified by his asserted concern for the fetal life. It subjected the patient to extreme and unnecessary pain during a non-emergency procedure, the purpose of which was to protect the mother's health. The inconsistencies in Respondent's explanations reveal inappropriate vacillations or lack of confidence in his own decisions.

Respondent's failure to try induction of labor with Pitocin first, following prolapse of the cord, subjected this patient to the extreme physical and emotional trauma of the Respondent's delivery efforts. These delivery efforts

** Line 14 through 18, where lined through, is deleted.

were a notable deviation from accepted obstetrical procedure. When they failed, the patient was further exposed to the risk of general anesthetic for a dilatation and curettage to remove the fetal remains on the following day.

The methods used by the Respondent in attempting to speed delivery of the unviable fetus foreseeably exposed the patient to the risk of significant damage to her cervix. The damage which Respondent noted had occurred may or may not have been repaired, and, if not repaired, would constitute a threat to the patient's future pregnancies.

B. Patient No. 041-190 (1975)

Retained Placenta.

This patient was admitted for delivery and experienced a normal delivery. After the delivery of the infant, only a portion of the placenta was delivered. The portion of placenta that was retained proved on subsequent pathological examination to be of such dimensions that it probably represented the larger part of the patient's placenta. (Dr. Hess) Respondent attempted for about an hour to remove the rest of the placenta, without success. (Exhibit D, pp. 4, 12) After the first fragments of placenta were removed, Respondent waited and watched for subsequent

contractions to deliver the balance of the placenta. By the time he decided it would be advisable for him to attempt to assist in the separation of the placenta from the uterus, the cervix had contracted to such an extent that he could not longer insert his hand into the uterine cavity. Respondent's lack of experience with this not unusual obstetrical complication, and his failure to consult immediately with a specialist, meant he lacked the necessary foundation on which to judge how much time he had to work on delivery of the placenta and how to go about it. (Dr. Hess)

At that time (approximately 9:00 p.m.), the operating room was not available and probably would not be for some hours. In addition, the surgical crew had already had an extended shift. Out of consideration for the operating crew, Respondent decided to postpone any surgical effort to deliver the placenta until Monday, some 36 hours later. Respondent recognized that the two major risks to the patient during this period would be from excess bleeding because of the failure of the uterus to contract, and from development of infection from the continued presence of foreign, non-viable material in the uterus. He took appropriate precautions against these risks by having the nursing staff watch the bleeding, by

transfusing the patient with whole blood, and by ordering antibiotics for the patient.

The patient was finally taken to surgery on the advice of Dr. Hess, then Chief of Obstetrics, some 24 hours after delivery of the infant. Dr. Hess was asked to step into the case by the hospital's Chief of Staff. During the induction of anesthesia, the patient coughed and the placenta was expelled. It is common for a retained placenta to be spontaneously expelled upon administration of anesthesia. Such an outcome would have been likely at any time following the delivery of the infant. (Dr. Hess)

Respondent did not call in a consultant in a situation in which he was faced with obstetrical complications. He did accept Dr. Hess' suggestion of immediate surgery once the Chief of Obstetrics had entered the case. Respondent's actions in this case were a significant deviation from accepted obstetrical practice. (Dr. Hess) * ~~It should be noted that during the labor period, some 45 minutes before the delivery, Dr. Storrs ordered the administration of Mepergan for this patient despite the warn-~~

* Line 14 through 20, where lined out, is deleted.

~~ing in the manufacturer's literature that such use "can produce respiratory depression in the newborn; -- resuscitation -- may -- be -- required." (Exhibit-D, -- p. --- 11, -- Exhibit-M) --- This case occurred -- some -- three -- years -- after -- Respondent asserted -- a -- more -- cautious -- pain -- relief -- program for the mother of an unviable fetus.~~

Conclusions

* Respondent's use of Mepergan during this patient's labor exposed her infant to an unnecessary -- and -- known -- risk -- of -- respiratory depression upon its delivery.

Because of his limited obstetrical experience and unfamiliarity with the then current state of the art regarding recognition of and treatment of retained placentas, Respondent did not act as promptly as he should have to remove the retained portion. This delay exposed the patient to a greatly increased risk of excessive bleeding and infection. Respondent then unnecessarily prolonged his patient's exposure to these risks, solely for hospital convenience, although he did try to protect against the foreseeable dangers.

** Line 22 through 24, where lined out, is deleted.

C. Patient No. 038-581 (1975)Facial Lacerations.

This patient was seen in the emergency room by Respondent following a mini-bike accident. She was diagnosed as suffering from a possible cerebral concussion and multiple lacerations and abrasions. In Respondent's description of his immediate treatment of the patient, he indicated that there were significant lacerations in the area of the left eyebrow, the area under the left eye, and the area under the left nostril. His report indicates that each of these areas was "thoroughly debrided" before being sutured. Debridement is a common and widely used medical procedure used to remove contaminated, devitalized and foreign material from wounds. When debridement has been thorough, there will be no traces of such materials apparent at the wound site after the wound has healed. If a thorough debridement of a laceration is not immediately possible, accepted surgical practice is not to suture and close the wound until it can be thoroughly cleaned. Otherwise, the patient has an increased risk of infection and of cosmetic defects resulting from pigmented foreign material moving deep within the skin where it cannot be removed except surgically. The only circumstances in which it would be appropriate to postpone thorough cleaning and suturing of

wounds would be if it were necessary to concentrate the doctor's efforts on life-saving procedures. (Wennen)

In the instant case, while the patient was diagnosed as having suffered a possible cerebral concussion, neither Respondent's recorded actions in the emergency room nor his subsequent orders indicated that he considered the patient to be in a condition that seriously threatened her life. In his office notes made the same day as his first treatment of the patient he makes no reference whatsoever to the possibility of concussion. (Exhibit 5) The hospital records included the results of a limited neurological examination. It is possible not all negative observations were recorded. Respondent has no present recollection of this patient. Respondent wrote no order for the nurses to make continued neurological observations, although they did do so. (Exhibit E, pp. 5, 10) Even if he were most concerned about the possible concussion, taking the time to do a thorough job on the lacerations would have given him additional time and opportunity to observe the patient's condition. Moreover, from the operation report of the steps taken in the emergency room it is obvious that Respondent knew it was appropriate at this time to clean the wounds thoroughly and intended to do so. (Exhibit E, p. 8)

The inadequacy of Respondent's cleaning of the facial lacerations became evidence some months later when the wounds had healed. The cosmetic disfiguration of the patient's face from foreign material left in the wounds was sufficient to cause her extreme embarrassment and eventually to take her to Dr. Wennen for cosmetic plastic surgery. (Dr. Wennen; Exhibit K, pp. 1-8) In the course of the plastic surgery required by this patient, Dr. Wennen discovered extensive retained foreign material at each of the wound sites, including, in the area under the left nostril, a "firm foreign body measuring 0.3 cm in diameter." (Exhibit F, pp. 9, 10)

Respondent testified that he asked the patient to come and see him after her discharge from the hospital and that she never appeared. He indicated that it would have been his intention at the time of such office visit to check the wounds for possible infection and to check the adequacy of their cleaning. He asserted that this postponement of attention to the facial lacerations was appropriate in light of the possible cerebral concussion. These assertions make no sense in light of the fact that the records do not indicate a significant concern or cause or concern over the patient's possible cerebral concussion. Further, it makes no sense to expect to do further work on

the wounds to clean them two or three days after they had been closed by suturing. (Wennen)

Conclusions

It would have been appropriate for Respondent to be most concerned in this case with the possibility of cerebral concussion. If he were, it should have been reflected in his written observations and orders to the nurses. In addition, such a concern would not have been inconsistent with the thorough cleaning of the wounds he knew was appropriate but did not accomplish. The inadequacies in Respondent's treatment reveal an inability to choose a correct course of treatment and to follow it through.

Respondent's inadequate performance of a basic, common medical procedure produced serious traumatic tattooing in this patient. While this turned out to be only a cosmetic problem, it was understandably important to this young woman and her associates. (Wennen) Eventually it meant exposure of the patient to the additional risks of further surgical procedures under general anesthesia to correct the conditions Respondent had not handled properly.

D. Patient No. 035-113 (1975)

Ileocecal Bypass.

This woman had been Respondent's patient for less than a month before he performed an ileocecal bypass operation on her as treatment for morbid obesity. There is no indication that he supervised her in any other weight loss programs. (Exhibit 2) The record reflects limited testing work-up and no psychological examination in preparation for the operation. There is no indication that Respondent explained the extensive possible complications of the operation to the patient. However, at the time of this operation, ileocecal bypasses were widely performed throughout the country without much more in the way of work-up of the patient. (Kemp) Only Respondent and Dr. Weston were doing this procedure in Fairbanks at the time. Still, the operation was not then in general disrepute among the Fairbanks medical community. After the date of this operation, the procedure did come into general disrepute both in Fairbanks medical community and in the national medical community. At the present time, it is performed much more limitedly, usually only in major medical centers, and usually only after more comprehensive patient work-up and preparation has been done. (Mylie, Doolittle, Grauman, Straatsma) The operation has come to be recognized as a

high-risk procedure because of a large number of possible post-operative complications, which are aggravated by the patient's obese condition and other possible pre-existing medical problems of the patient related to his or her obesity, and some of which take an extended period of time to develop. (Mylie, Kemp)

The operation was performed on March 5. Respondent's performance of this operation was technically competent in that the procedure was properly performed, and the anastomoses were adequately sutured. (Exhibit B, p. 281) Respondent's decision not to use retention sutures in closing the wound was justified because of the stress they put on the tissue and the problems that causes. (Storrs, Kemp)

Respondent's decision to require that dressings be changed only by himself was an acceptable means of obtaining information on drainage at the wound site. However, he failed to give adequate consideration and timely response to information thus obtained and to other symptoms of developing post-surgical complications which appeared as early as the second post-operative day (March 7). The patient complained of nausea, with some vomiting, beginning on the second post-operative day, and continuing, despite medication, for seven days. The patient complained of feeling weak. (Exhibit B, pp. 91-97, 172-175) From

the fourth post-operative day through the eleventh post-operative day, the patient's pulse was noticeably elevated. Her temperature was spiking on the seventh through eleventh post-operative days. (Exhibit B, pp. 142-143)

On the seventh and eighth post-operative days, the patient was anxious, depressed, and felt she was going to die. (Exhibit B, pp. 175-176, 18). Notable amounts of drainage did not begin until the third post-operative day when, within twelve hours, the amount of drainage increased so substantially that the dressings had to be reinforced several times between Respondent's visits. On the fourth post-operative day, Respondent removed the drain from the wound despite the large amounts of drainage. (Exhibit B, pp. 173-175)

Through the sixth post-operative day (March 11), despite the developing symptoms, Respondent made no attempt to explore the depths of the wound to determine whether the foreseeable complication of wound dehiscence (separation) had occurred and to check on whether a loop of the bowel might be caught in the opened wound. (Borden) On the seventh post-operative day, because the patient's abdomen was distended and she complained of pain, Respondent did explore the drainage site sufficiently to release a large quantity of fluid. He described the fluid as transudate,

suggesting normal tissue seepage, while the nurse described it as "foul-smelling cloudy drainage." (Exhibit B, pp. 95, 175) Respondent did have this drainage cultured. (Exhibit B, p. 36) He also ordered a CBC which established that, over a two-day period, the patient's white blood count had risen sharply. (Exhibit B, p. 20)

Respondent started the patient on antibiotics before the culture report was returned. He did not prescribe a drug to which gram negative bacteria would be sensitive, even though he should have suspected from the nature and odor of the drainage that it would contain gram negative bacteria. (Mylie; Exhibit B, p. 36) On the next day, Respondent changed the medication to one which was effective from gram negative bacteria. Respondent also consulted with an internist on the eighth post-operative day (March 13). He consulted with three other surgeons, beginning with Dr. Weston, his assistant in the operation, on the ninth post-operative day. (Exhibit B, pp. 97-98) On the eleventh post-operative day, the patient was confused and demonstrated other symptoms of toxicity. All the symptoms at this point indicated generalized peritonitis. (Mylie, Grauman, Marrow)

On the tenth post-operative day (March 15), a series of X-ray examinations explored

the area around the internal end of the fistula that had developed to the surface of the patient's abdomen. The fistula was diagnosed, after these X-rays, as representing a breakdown in the anastomosis between the bypassed bowel and the sigmoid colon. This diagnosis subsequently proved to be in error. However, the X-ray examination also identified "one ramification of the sinus tract which extends into the peritonium on the patient's right." (Exhibit B, p. 58) The findings in the subsequent autopsy indicated that this ramification or opening would have been at the site of the necrotic portion of the bowel which had become entrapped in the separated deep fascia of the wound. Some of the witnesses (Kemp, Storrs) testified the use of a Foley catheter and contrast fluid to do these X-rays were the likely causes of the patient's peritonitis. Substantial testimony (e.g., Grauman, Borden, Mylie) on the earlier presence of symptoms of peritonitis and the safety of using the contrast fluid, together with the autopsy findings regarding the entrapment of a portion of the bowel, leads to rejection of this theory. In any event, Respondent was still in charge of the patient's care and was present at the examination in question. He is therefore, as the treating physician, responsible for the decisions made as to her treatment and for

consequences thereof, even if the treatment was recommended by one or more consultants. These were, in addition, consultants chosen by Respondent, who was aware of the problem of potentially conflicting recommendations, but who had the ultimate responsibility for making the choice among such recommendations.

The summary conclusion of the pathologist's autopsy report was that the causes of death were septicemia and multiple abscess formation, which "can best be attributed to dehiscence, strangulation of the trapped loop of bowel, and leakage leading to intra-abdominal abscess formation." (Exhibit B, p. 285) These are the developments Respondent should have suspected and responded to at least by March 12. Thus, it was neither the fact of the operation, nor the fact of the patient's eventual death, that is the cause of concern in this case. Rather, it is the course of treatment that Respondent pursued during the time after the operation and before he was replaced on the case. The reasonable expectation of a patient in the position of this one would be, not that there would be no post-operative complications, and not that dehiscence could absolutely be avoided, but that once it was suspected to have occurred, it would be treated promptly and appropriately.

Conclusions

This patient, because of her obesity, was already a high-risk patient. She was subjected to a high risk operation after a very limited work-up, although the work-up was consistent with general practice in this operation at the time. The operation itself was adequately performed technically.

However, Respondent greatly increased the risk to this already exposed patient by certain failures in his post-operative treatment. He failed to take early steps to explore the wound to determine whether wound dehiscence had occurred. Had he made that determination early enough, the patient's condition might still have been good enough that she could have been returned to surgery for repair had that been deemed appropriate. Respondent also failed to diagnose wound dehiscence and developing peritonitis from accumulating symptoms of the patient's deteriorating condition, especially the large amounts of increasingly foul drainage and systemic decline. Respondent's treatment attempts appeared to be directed simply and ineffectually at repressing various symptoms as they appeared, rather than to diagnosis of the cause and correction of the dehiscence and its consequences. The failure to react promptly and appropriately meant that the patient's condition deteriorated so greatly that treat-

ment alternatives were reduced, and her body's ability to respond was seriously compromised, thus exacerbating and prolonging her exposure to the risks of this operations and its complications.

E. Patient No. 025-466 (1977)

Liver Biopsy.

This patient was over 70 years of age, was obese, and had some indications of poor cardiovascular condition when he entered the hospital. He should have been assumed to be a patient for whom bleeding following a liver biopsy, a predictable complication, would constitute a higher risk to his general condition. (Doolittle, Grauman)

The liver biopsy was performed for diagnostic purposes at a time when the underlying condition was resolving itself. It was a purely elective procedure and there was no urgent need that it be done at the particular time or on the particular day when it was performed. (Doolittle, Partnow)

The operation was performed on March 11, 1977. On March 5, the patient's hematocrit measured 34.5. On March 7, it measured 27. On March 8, it measured 35. The March 7 volume was below the acceptable range for performing this operation in a normally healthy patient. No further blood work was ordered before the

biopsy three days later. But an inadequate value was recorded on March 9, at 25, which would also have been below the acceptable range. Further blood work on the day before the procedure was planned was indicated in order to establish with some certainty the true level of this patient's hematocrit. (Dootlittle, Grauman) Without having determined whether the low hematocrits were errors, it would be difficult to know whether the operation was indeed safe and what operative precautions would be necessary. (Dootlittle, Partnow, Grauman) When he decided to do the liver biopsy, Respondent did not order blood typed and cross-matched to be available for this patient at the time of the procedure and immediately following it. Respondent had ordered two units of blood on March 7, but he had sufficient experience with the hospital and blood bank practices regarding holding blood to know that there was substantial reason to doubt it would still be available four days later. It was Respondent's responsibility, in light of the known practice of the blood bank regarding holding blood, to inquire as to whether the blood was still available and to order two units of blood typed and cross-matched if not. Insuring the availability of the blood before the procedure was undertaken was particularly critical, given the age and physical condition

of this patient.

Respondent had not been adequately trained in the performance of percutaneous liver biopsies and should have used one of us internist consultants to do it. There is a considerable difference between doing this procedure blind, through the abdomen, and doing it under vision with the abdominal cavity open in surgery. Respondent's experience was primarily with the latter, in which it is much easier to avoid many of the possible errors of location and penetration of other organs.

The usual approach for a percutaneous liver biopsy is laterally through the ribs. This is the preferred approach because it involves lower risk of excess damage to the liver and surrounding organs, and because, by post-operative positioning of the patient, it allows the liver itself to exert pressure on the site of the biopsy to reduce bleeding. Variations from this approach are used only when necessary to reach a particular area of diseased tissue that the doctor wishes to sample. Respondent used an anterior approach, even though there was no known or suspected growth to be biopsied. He asserts that this decision was based on the radiological evidence of pneumonia on the patient's left side. The clinical evidence indicated that there was no pneumonia and no concern on the patient's right

side, where the liver was located. (Mylie, Partnow, Grauman, Doolittle)

Respondent's post-operative orders were not strict enough to protect the patient by keeping him flat and by requiring the nurses to measure vital signs frequently enough for long enough.

Although the patient's blood pressure remained relatively stable for the first two hours after the biopsy, he did exhibit other symptoms which suggested the possibility of bleeding, i.e., complaints of pain around the biopsy site (9:45-10:30 a.m.) and diaphoresis, or sweating, (11:00 a.m.) (Exhibit A, p. 87) Respondent's response to these symptoms, as he was informed of them, was simply to attempt to alleviate the symptoms rather than to investigate and determine their cause. Thus, his order at 10:15 a.m. to give Mepergan was an attempt to reduce or eliminate the complained of pain instead of being wary that the pain was probably a sign of bleeding. In addition, the use of Mepergan in these circumstances was a serious error regardless of the intended effect because, as the manufacturer's literature explains, it may produce "severe hypotension in an individual whose ability to maintain his blood pressure has already been compromised by a depleted blood volume ..." (Exhibit M) The order to administer oxygen might have been to

increase the amount of oxygen being distributed by the blood, but it would not have stopped blood loss that was occurring nor would it have replaced the lost blood volume needed to carry the oxygen. The final order given at 10:15 a.m., to put pressure on the biopsy site, was patently senseless since the anterior approach by definition avoids any anatomical support against which the biopsy site on the liver could be pressed. Similarly, the 10:45 a.m. order of 1 cc. of Ephedrine might have altered the symptom of falling blood pressure, but since it would have done nothing to replace lost blood volume it would only work to mask the evidence of the deteriorating situation.

The first order directed at replacing lost volume was given at 11:45 a.m. But even that order was inadequate because Respondent specified Ringer's Lactate, a volume expander, instead of the needed whole blood. Ringer's Lactate would have been an acceptable interim step while whole blood was being typed and cross-matched, a procedure which, on notification of an emergency, could be completed in about 45 minutes. Respondent did not order whole blood for another 75 minutes and he ordered Ringer's Lactate against after that. (Exhibit A, p. 55) Even then, Respondent did not see that the order for whole blood was transmitted as urgently as it needed to be. He

testified that he went to the blood bank himself to speed the process, but the records indicate the order was not sent to the lab until 2:00 p.m. (Exhibit A, p. 73) The blood was received back and the transfusion started within 45 minutes of the order being transmittal to the lab, but this was some three hours after the patient's vital signs indicated an urgent need.

Respondent's testimony confirms the impression created by his conduct of the case that he had no appreciation of the source, extent and development of bleeding likely to occur after a liver biopsy. Others testified that the liver, being a many-vesseled organ, was highly likely to bleed after a biopsy, but that the bleeding could take an extended period of time to manifest itself. (Mylie, Grauman) Respondent believed his experience with visually done biopsies that showed no bleeding within several minutes meant bleeding was uncommon. (Storrs)

Respondent failed to take other important diagnostic steps in a timely manner. A Foley catheter should have been used to measure kidney output to watch for signs of kidney failure. Although there are two references to a Foley catheter, without times, a catheter was not inserted until Dr. Montano arrived, and inserted it, after 2:00 p.m. Similarly, a

central venous pressure line would have given a truer measure of the patient's blood pressure and circulating volume. A CVP line was not inserted until Dr. Montano arrived, either. Finally, the consulting internist, Dr. Partnow, was not called in until Dr. Montano ordered him contacted at 3:45 p.m. (Exhibit A, pp. 55-56; Montano)

The patient died the next morning of irreversible hemorrhagic shock which had led to multiple organ failures and cardiac arrest.

Conclusion

This patient was a high-risk patient before the liver biopsy, an elective, though potentially helpful, diagnostic tool, was performed. Respondent did nothing prior to the procedure to protect against any of the foreseeable risks, such as redoing the blood count to see which report was in error and ordering blood typed and cross-matched. He should have used a lateral approach for the biopsy itself to gain the benefit of possible pressure to reduce bleeding and to avoid the extra risks of a badly placed biopsy needle.

His post-operative orders also failed to take into account the high-risk character of the patient's general health, in that he did not require complete flat bed rest for several hours after the procedure and frequent monitoring of vital signs even after the first hour.

Moreover, as symptoms suggestive of bleeding at the biopsy site began to develop, Respondent's orders were consistently addressed to repressing the symptoms rather than to diagnosing and treating the underlying condition. In particular, Respondent's failure to order and administer whole blood at 11:45 a.m., when he ordered Ringer's Lactate, probably cost this patient his life.

Respondent's use of Mepergan for this patient may have further complicated his developing hypotensive condition.

Respondent's performance of this procedure reflects a lack of knowledge and skill about the procedure as well as a lack of understanding of the likely impact of the procedure on this patient's blood circulation. His post-operative orders, his responses to the symptoms and his testimony reveal no expectation or suspicion of the most common complication with this procedure. Further, his handling of the treatment once the patient's condition had become an obvious emergency was not systematically directed toward replenishing the blood volume. It was only after the intervention of two consultants that urgent comprehensive treatment was given to this patient.

F. Other Findings and Conclusions.

Respondent did use consultants in these cases. He has shown little hesitancy in consulting with internists over the years, and prior to 1970 had a particularly close working relationship with Dr. Marrow. His reliance on Dr. Doolittle and his partners is somewhat less intense. However, the frequency of Respondent's consultations and the use made of them decreases markedly in the areas of his usual practice, i.e., surgery and obstetrics. In neither of the obstetrical cases presented did he recognize that he faced a complication for which he should obtain a consultation. In the two surgical cases, he also failed to recognize common and foreseeable complications as they developed, and when he did call in the consultants, it was either too late, as in the liver biopsy case, or he was unable to sift through the recommendation made by this consultants to find an appropriate course of treatment, as in the intestinal bypass case.

The correlation between the termination of Respondent's close working relationship with Dr. Marrow, because of Dr. Marrow's departure from town, and the appearance of the patterns of inadequacy and failure reflected in the above cases may be more than coincidental. It is quite possible that during the time Respondent worked with Dr. Marrow, the complementary

knowledge and skills of the two doctors prevented the occurrence of the kinds of problems indicated in the above cases. However, it is quite clear that at the present time Respondent has no such complementary working relationship with any other physician in town, not even with Dr. Doolittle. Therefore, at the present time there is no reason to believe that it would be possible for Respondent, by continuing a close working relationship with another doctor in town, to avoid the patterns revealed by the above cases and the consequences to his patients.

Respondent presented testimony to support his contention that he worked hard at keeping his skills and technical knowledge as up to date as possible. From the evidence, it appears that Respondent's efforts in this direction have indeed been extraordinary, and have been at least the equal of most practitioners in Fairbanks. Of course, these continuing education efforts work primarily to maintain the currency of one's medical knowledge and skills. They do not necessarily improve one's judgment, and apparently had had no such impact upon Respondent's judgment in the exercise of his knowledge and skills. At the same time, Respondent has allowed his relationships with certain doctors in Fairbanks to interfere with his opportunities to improve his

knowledge and skills by learning from their expertise (e.g., Wennen on burns, * Worrall Straatsma on hysterectomies).

UNPROFESSIONAL CONDUCT

Scheduling Of July 1976 Operation As A Violation Of Principles Of Medical Ethics

The Fairbanks Memorial Hospital schedule of operations for July 8, 1976, indicates that Respondent scheduled an exploratory laparotomy for 8:00 a.m. on that date. Respondent's testimony indicates that at the time he scheduled the operation, he was not certain whether he would first have to do a gallstone operation or whether he would be able on July 8 to do an intestinal bypass for this patient. The patient wanted an intestinal bypass, but Respondent was awaiting reports of tests that had been performed on her previously by doctors in the State of Washington before making his decision. The testimony further indicates that at some time prior to the July 4 weekend, Respondent had received the information necessary for him to make his decision as to

* Line 4, where lined out, is deleted and changed to Worrall, a correction.

the nature of the operation on July 8. He did not, however, communicate that decision to the operating room supervisor until July 5. (Exhibit 1, Deposition of Ethel Ghezzi) After the operating room supervisor was advised to change the description of the operation to be performed on July 8, 1976, to intestinal bypass, the operation was cancelled by Dr. George Murphy, Chief of Surgery.

In April, 1975, following the death of the above-described ileojejunal or intestinal bypass patient (see D above), the combined staffs of the Surgery and Medicine Departments of Fairbanks Memorial Hospital had decided that such operations should not be performed in the Fairbanks Memorial Hospital until the procedure had been reviewed and its suitability determined. Respondent was present at the meeting on April 10, 1975, at which the death of his patient was discussed, and at which this decision was made. (Exhibit J; testimony of Dr. Murphy and Mr. Finneseth) Respondent had received no further communications from the hospital indicating that the procedure had been thoroughly reviewed or that its suitability for performance in Fairbanks Memorial Hospital had been determined. (Storrs) Neither had he inquired of the chairman of the Surgery Department or any other person in authority at Fairbanks Memorial Hospital whether, in fact,

performance of that operation was against being allowed.

The motion passed on April 10, 1975 which instituted the local profession's ban on this operation was, "The chairman or assistant or vice-chairman of this Department will exercise their authority to cancel any further jejunal bypasses until this procedure has been thoroughly reviewed and its suitability for this hospital determined, including the criteria for operation." (Exhibit J) This section of the motion was voted upon by a voice vote and unanimously passed. According to Dr. Murphy's testimony, Respondent did not vote against the motion, although he may have abstained from voting.

Respondent's colleague, Dr. John Weston, who had also performed ileojejunum bypasses in the past, was aware of the ban and did not attempt to schedule any such operations in Fairbanks, but referred such patients to doctors in other cities. (Weston)

Dr. Murphy's action in cancelling Respondent's scheduled operation was authorized and mandated by the motion adopted with Respondent's knowledge on April 10, 1975. Respondent's failure to check with the authorities before scheduling a patient for whom he eventually intended to do the banned operation and his late change in the descrip-

tion of the proposed operation resulted in the hospital's having to tell the patient, when she checked in for admission, that the operation could not be performed. Although the hospital officials do not remember her reaction in their presence to this information, Respondent's testimony is that when she came to him from the hospital, she was upset, crying and greatly inconvenienced by the cancellation of the operation.

CONCLUSIONS OF LAW

The ban established by the staff of the Fairbanks Memorial Hospital was a "self-imposed discipline" of the Fairbanks medical profession. Respondent had adequate notice of the ban and no notice of its being removed.

Nevertheless, Respondent's scheduling of an intestinal bypass, which was then cancelled by the chairman of the hospital's Department of Surgery pursuant to the April 10, 1976, motion, was not a refusal to accept the profession's self-imposed disciplines, since it conformed to the procedure implicit in the motion as adopted.

The only allegation of the State relating to unprofessional conduct is that the scheduling constituted a refusal to accept self-imposed disciplines. The way in which Respondent handled this patient's desire to have the

banned operation might also have been a violation of Section 1 of the American Medical Association's Principals of Medical Ethics, which states that "[t]he principal objective of the medical association is to render service to humanity with full respect for the dignity of man ... [and to render] to each a full measure of service and devotion." Had Respondent made the effort of asking appropriate hospital authorities or his colleagues about the continuance of the ban, Respondent could have avoided the embarrassment, pain and inconvenience that his patient suffered because of the late cancellation of the operation. By not pursuing a more direct means of discovering whether he could perform the desired operation, Respondent permitted the state of his relationship with his colleagues in Fairbanks and with the hospital to interfere with his duty of full consideration and respect for his patient. However, even if this issue could be assumed to have been tried without objection by the parties by virtue of the testimony that was presented at the hearing, to the extent this apparent violation of the principles of medical ethics of the American Medical Association is at issue, it is such a limited instance of lack of consideration that it cannot, in and of itself, form adequate grounds for any licensure action against Respondent.

SUMMARY AND RECOMMENDATIONS

The patterns of errors and omissions revealed by the evidence presented in this hearing go beyond the range of foreseeable and acceptable variations in treatment in the medical profession. Where it is only a question of technical performance of a skill, Respondent appears competent. Where, however, it is a question of interpretation of symptoms, of response to symptoms, and of judgment used in applying both medical knowledge and technical skills, Respondent's course of treatment in the cases presented greatly increased the exposure of his patients to the risks of injury, pain and death.

The cases have several characteristics in common. Each of them involved some point at which the seriousness of the patient's condition created a highly pressured context for decision making and for performance of Respondent's professional duties. In each, most of the errors or omissions were made in the context of the existing or developing crisis. In the facial lacerations case, Respondent failed to perform as adequately as his records claimed, a basic emergency room procedure. He may have been distracted from so doing by the possibility of a cerebral concussion, but he did not follow up on that concern adequately

either. With the prolapsed cord, Respondent's conduct revealed considerable confusion over which patient, the mother or the unviable fetus, he was trying to protect, with the result that his treatment helped neither situation. With the retained placenta, Respondent's lack of experience prevented him from taking prompt enough steps to aid the immediate delivery of the placenta, and after that from seeking a timely resolution of the complication. In the intestinal bypass case, Respondent's treatment ranged from underreaction to developing symptoms until they had passed the point of being safely manageable, to overreaction with a multiplicity of consultants and treatment courses once the patient had become toxic. Finally, in the liver biopsy case, Respondent again underreacted to the developing symptoms until it became obvious that the patient was in critical condition, after which most of the necessary corrective steps were taken by consultants called in too late.

In each case the oversights or errors appear to be in matters of fairly basic medical knowledge or skill: e.g., debridement of lacerations, use of Mepergan in circumstances specifically warned against in the manufacturer's literature, treatment of a mother with a prolapsed cord and an unviable fetus, treatment for a retained placenta, treatment of the

complication of wound dehiscence in an obese patient and of developing peritonitis, treatment of developing hemorrhagic shock.

The patterns of inadequacy and failure suggested by these cases include inability to foresee and recognize common complications and inability to recognize a need for a consultation regarding a developing complication, and inability to identify and apply the most direct and appropriate diagnostic and corrective measures once a complications has developed.

The quality of Respondent's consultative relationships declines markedly in areas that he considers to be his own areas of practice. It may be, as Dr. Doolittle suggested, that Respondent's medical judgment is weakened because of the extent of his ego investment in the steps or decisions already made before he obtains consultation. It may be that Respondent's ability to analyze and thoroughly understand the nature of the problem and appropriate available remedies is limited. It may be that Respondent lacks confidence in his own decision making. Whatever the reason for Respondent's hesitancy in identifying and following through with a coherent or systematic course of treatment, for his vacillations and inconsistent treatment efforts, it is clear that his patients have suffered from these patterns of behavior in the past. It is further clear that

the patterns are so pervasive in Respondent's professional conduct that his patients are likely to continue to suffer from exposure to increased risk of pain, injury and even death, as a result of these patterns.

Because of the pervasive quality of these patterns, it appears the only means of protecting the public is to revoke Respondent's license.

Dated at Fairbanks, Alaska this 19th day of December, 1980.

/S/ D. Rebecca Snow
D. REBECCA SNOW,
Hearing Officer

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND
ECONOMIC DEVELOPMENT
BEFORE THE STATE MEDICAL BOARD

In the Matter of)	
)	
PETER S. ROSI,	)	MEMORANDUM OF DECISION
)	
Physician and	)	No. ME 80-09
Surgeon.)	
)	
)	

This case centers around the proper method and treatment of an infant boy during and after his birth. Specifically, the case focuses on the medical assistance rendered by Dr. Rosi during and after the birth of a child in the home of Susan and John Stednick. The birth occurred in the home of the Stednicks by their choice, and that fact, in and of itself, requires comment. Underlying the specific charges against Dr. Rosi is a basic conflict in the Sitka community regarding the philosophy of medical care and assistance to an expectant mother for her pregnancy. As will be explained below, that conflict concerned the role of the medical profession in the process of giving birth to a child, and the divergent attitudes of Dr. Rosi on the one hand and the medical community of Sitka on the other hand are significant to this case; and, unfortunately,

they may have had an impact on the care and treatment of the infant, Joseph Stednick.

The medical community of Sitka followed the traditional scientific theory that birth is a medical problem that needs treatment, and the birth of a child should occur in a hospital. The medical community in Sitka discouraged home births. (Berner, Hrg. 172 through 174) In contrast, Dr. Rosi felt that childbirth was not a medical problem to be treated, but was a natural process to be observed, and the natural process would involve his medical training only if something went wrong during birth. (Rosi, Hrg. 260-261) Dr. Rosi summarized his philosophy eloquently at the hearing:

" ... (B)ack when I ws in my residency and internship programs, (I found) that I could learn from people other than doctors. I could learn from nurses and I even found that I actually could learn from patients by listening what they had to say and considering what their thoughts were on the subject of their medical problems ...

Once I got into working in the patient's home, I found that the ground rules under which an attendant at birth works are much different than the ground rules in the hospital. In the hospital, I'm on my own turf. I'm uncomfortable. They're uncomfortable. In the home, I'm their guest. They're comfortable. I'm uncomfortable. It changes the

whole circumstances of the experience. It makes one more respectful towards your host, towards respecting their wishes.

I also learned by participating in home birth that there are many things, many habits, and many practices I have when working in the hospital that were irrelevant, that didn't make any difference. That were just nuisances that changed my hospital practices. Once I did that, I became increasingly in conflict with the other doctors in the Sitka hospital." (Rosi, Hrg. 262 through 264)

The difference in the two philosophies is obvious. The traditional medical approach to birth is to have it occur in a laboratory setting. The advocates of home birth prefer the family home environment. The synthesis of these two philosophies has been recognized recently in hospitals throughout the United States. Maternity wards and labor rooms have been humanized as much as possible in an effort to make the birth process as comfortable and unlaboratory-like as possible. Unfortunately, in the present case, the personalities representing the divergent philosophies remained in conflict. As a result of the conflict, communication was poor, and Dr. Rosi and the medical community seemed to go their separate ways. C. P. Snow addressed philosophical conflict on a much broader scale,

but a quote from his famous essay is appropriate:

"Between the two a gulf of mutual incomprehension -- sometimes ... hostility and dislike, but most of all lack of understanding. They have a curious distorted image of each other. Their attitudes are so different that even on the level of emotion, they can't find much common ground." Two Cultures, p. 4.

Thus, when Joseph Stednick was in serious medical difficulty, Dr. Rosi explained his reason for failing to call Dr. Chiappinelli at Sitka Community Hospital by saying, "Because I knew he was hostile to home birth and it probably wouldn't get me anything except a lot of noise." (Rosi, Hrg. 285) With that undercurrent as background, we can examine the birth of Joseph Stednick.

FACTUAL BACKGROUND

Susan Stednick had decided on home birth and had chosen Dr. Peter S. Rosi, the only physician experienced with home birth delivery in Sitka, to be her physician. According to the testimony of Dr. Rosi, approximately twenty-three hours before birth Mrs. Stednick had "leaking membranes" and "a small amount of fluid came out ... " (Rosi, Hrg. 190) Mrs. Stednick was in "active labor" for a period of eight hours, beginning approximately sixteen

hours after the membranes began to leak. Dr. Rosi and his home delivery team were present and monitoring Mrs. Stednick during this period. She had a normal temperature and, except for one incident two and one-half hours before the birth when the fetal heart tones were detected at a rate of 168-178, the fetal heart tones were maintaining steadily at 144. The rise in heart tones occurred only once, and no evidence was introduced to explain it. Except for this one instance, the labor proceeded normally.

Though the labor was long and difficult, Dr. Rosi had no indication of a serious problem developing.¹ As the baby's head was produced, it was accompanied by a thick gush of meconium. The meconium was in and around the mouth and nose of the baby "during the couple

¹ Dr. Berner testified that the fact the membranes ruptured prematurely, and the labor was prolonged, should have alerted Dr. Rosi that trouble was possible and hospitalization would be prudent. (Berner, Hrg. 45-47) This opinion of Dr. Berner's appeared to come more from his bias against home birth than from his medical judgment that the mother exhibited sufficient danger signals to warrant hospitalization. Therefore, I find that Dr. Rosi did not exhibit any conduct which was improper during and up to the actual birth of Joseph Stednick.

of minutes that the baby's head was out". (Rosi, Hrg. 195) Dr. Rosi recognized that a medical emergency existed, and he acted. He began suctioning first with the bulb syringe and then attempted to introduce a DeLee suction line into the baby's nose and mouth and eventually down the trachea. His main concern was with removing as much of the meconium from the nose and mouth of the child as he could.

Dr. Rosi had allowed the birth to proceed naturally, without an episiotomy, and he continued to allow a natural birth; that is, to allow the baby to deliver spontaneously through the efforts of the mother rather than attempt to speed the delivery through medical assistance (i.e., performing an episiotomy or manually assisting in the delivery of the baby). (Rosi, Hrg., 194-195) Within approximately three minutes the birth was completed. Immediately upon delivery of the baby, Dr. Rosi began resuscitation efforts. He did not use the Lairdol bag which was present, because he was handed an oxygen line rather than the Lairdol bag. He began resuscitation by tapping the oxygen line gently into the endotracheal tube to deliver the oxygen. Though the Lairdol bag would have been better, Dr. Rosi continued with this method "because it worked" and "(I)'m a Surgeon, and I was taught a long time ago that, if you have something that's working in

your hands, don't put it down and go look for another tool, that's wasting time." (Rosi, Hrg. 202) The baby's pulse rate was 120 and within a minute or two after administering oxygen, the baby began to respond.

The subsequent events occurred in a less hectic environment. The baby had aspirated some meconium and was described by Dr. Rosi variously throughout his testimony as being "in terrible shape" (Rosi, Hrg. 202), suffering from asphyxiation and then hypernea or rapid shallow breathing (Rosi, Hrg. 204); "just about dead" (Rosi, Hrg. 203); "in very severe condition, in bad condition at birth." (Rosi, Hrg. 243) In commenting on the immediate emergency treatment of the baby, Dr. Berner suggests that the efforts to suction the baby could have begun sooner, the method of resuscitation could have been improved, and that a doctor proficient in the practice of delivering babies should have measured up to the standard he set in his testimony. (Rosi, Hrg. 54, 57).

Specifically, Dr. Berner testified that he would have responded to the emergency by insuring the baby would be delivered as quickly as possible. This, he testified, by manually maneuvering the baby or by doing an episiotomy to speed up the process. (Berner, Hrg. 51-52) Although Dr. Rosi may not have acted as quickly

in face of the medical emergency as Dr. Berner or Dr. Chiappinelli would like, it is difficult to criticize the performance in this emergency, since hindsight is so much more stark and clear juxtaposed to the frantic blur of approximately one hundred and eighty seconds of activity in a medical emergency. While Dr. Berner may in fact be correct in stating that Dr. Rosi could have been more efficient in his actions, the evidence was inconclusive and the criticism, if proven, would not be sufficient to support an action to restrict Dr. Rosi's license.

The presence of meconium constituted a medical emergency, but the presence of meconium also indicated that the baby had suffered an insult of some sort which precipitated the meconium. Since meconium is not produced without some sort of trauma to the baby, the second emergency was to discover the source of the trauma and determine whether the child was still under medical distress. Though the source of the trauma precipitating the meconium was never pinpointed, the baby exhibited symptoms of hyperpnea indicating continuing respiratory distress.

Within five or ten minutes of the birth of the child's color improved, and the child began to cry in a peculiar, monotonous, bleating tone. (Rosi, Hrg. 204-205) Dr. Rosi described the baby at age twenty to twenty-five minutes

as "doing just fine, with breathing and pulse rate and doing just terrible, dead, in all other characteristics," (Rosi, Hrg. 205). The child had aspirated meconium, had been asphyziated at birth and was obviously distressed. Meconium, because of its high acidity, causes the lungs to blister if it is inhaled. Various methods of testing the damage as a result of meconium aspiration and treating the symptoms were offered in testimony. Testing and treatment was available at two hospitals in Sitka, and consultation was available both in Sitka, and, presumably, Juneau or Seattle. However, for the next two to three hours, Dr. Rosi remained in attendance, periodically sucking out the nose and mouth of the child, checking the child's temperature and attempting to stimulate manually the clearing of the meconium from the baby's lungs. Dr. Rosi had been awake for approximately twenty-four hours, and between 4:30 and 5:00 a.m., he left a member of the home birth team in attendance while he went home to get some sleep. At approximately 5:35 a.m. the home delivery nurse contacted Dr. Rosi with information that the temperature in the baby had risen to 101°. (Rosi Trial 20, 65; Beck Hrg. 16) Approximately one and one-half hours after the phone call, Dr. Rosi returned to the Stednick home and the child was hospitalized shortly there-

after. The baby died some time after 10:00 p.m. on May 31, 1979, with the cause of death, aspiration of meconium which led in turn to chemical pneumonia and to hypoxia and atelectasis and the lungs became so infected that there was no adequate exchange of gases. (Memorandum of Decision of Judge Schulz, April 12, 1980).

ISSUE BEFORE LICENSING BOARD

As concisely stated by Dr. Rosi's attorney in the prehearing brief:

"Clearly, in proceedings of this nature, the strong interests of the physician in being allowed to practice his profession must be balanced with the interest of the public in allowing only competent practitioners to be licensed."
(Rosi, Prehearing Brief. p. 6)

Thus, the result of the care of Dr. Rosi is not a factor in the case. That is, we are not bound in this proceeding to find whether or not the actions of Dr. Rosi caused the death of Joseph Stednick or were a substantial factor in causing the death of Joseph Stednick. In this manner, the issue before the licensing board is far different from that before the Superior Court Judge hearing the criminal charges being brought against Dr. Rosi. The charges brought by the Division of Occupational Licensing call into question the ability of Dr. Rosi to

practice competently in the field of family practice, obstetrics and surgery. This Board must examine the actions of Dr. Rosi to determine whether they are actions of one competent to practice in this field.

The Board is not so concerned with the success or failure of the medical treatment given. Rather, the Board is concerned that whatever the outcome, the treatment of the doctor was proper for the symptoms exhibited in the patient. In this regard, the Board must examine the actions taken by Dr. Rosi, and in addition, where he has attempted to explain his actions or failure to act, the Board must examine those explanations to determine whether Dr. Rosi has the judgment necessary to practice competently in his fields of work.

The difficulty is compounded by the fact that Dr. Rosi's competence has been challenged on the basis of his treatment of a single patient. Dr. Rosi has argued that because he has been successful in treating many, many patients, one instance of improper conduct, if proved, would not substantiate an action against his license. I find this argument without merit. The issue is not one of numbers as much as it is one of degrees. One serious incident of gross misconduct would certainly support a finding that the interest of the public dictates insuring that gross misconduct

would not occur again. Similarly, numerous instances of misconduct to a lesser degree, would also dictate an action by the licensing board to protect the interests of the public.

The difficulty lies in distinguishing between simple errors and serious errors. A simple error would be one attributable to the frailties of human nature and would occur despite one's training, competence and ability, i.e., momentary carelessness, errors attributable to lack of sleep, simple mistakes. Another type of error, the more serious, is one that demonstrates an overall lack of competence or medical judgment or ability to practice medicine. A third category of error is that which occurs in misinterpreting the subtle inter-relationships of a large complicated set of data. This contrasts with the misinterpretation of a simple and obvious fact or abnormality.

FINDINGS

In determining whether or not action should be taken against Dr. Rosi's license, the Board must determine whether or not Dr. Rosi has exhibited conduct which demonstrates that he is professionally incompetent. Professional incompetence is defined as:

"lacking in sufficient skills or knowledge or both, in that field of

practice in which the physician concerned engages, to a degree likely to endanger the health of his patients."²

If professional misconduct is found, licenses may be suspended, limited, revoked or annulled, or the licensee may be reprimanded, censured, or disciplined.³ Because the licensing board has numerous options in acting upon the licensing of a doctor, it would follow that the statute anticipated various levels of professional incompetence with concomitant levels of licensing restriction.

As stated earlier, Dr. Rosi's actions up to and immediately after the birth of Joseph Stednick, while criticized, certainly would not support the finding of professional incompetence in any manner. The birth was at home by the choice of the Stednick's; Dr. Rosi faced a medical emergency in that setting and dealt with the immediate emergency of the child being

² 12 AAC 40.970

³ AS 08.64.330(b)

born accompanied by a thick gush of meconium as best he could under the emergency circumstances. After the immediate emergency had been treated and the life and death crisis of resuscitating the baby was accomplished, Dr. Rosi's actions are difficult to understand.

For reasons inadequately explained by Dr. Rosi both in the transcript from the criminal trial and at the hearing, the child was not hospitalized, nor did Dr. Rosi attempt to enlist the assistance of another doctor after the infant was stabilized. The infant was suffering from severe respiratory distress, and he had aspirated meconium. The two facts were obvious to Dr. Rosi, but he chose to allow the child to remain at the Stednick home under his care. This was not a subtle medical problem to be interpreted amidst a multitude of other subtle medical phenomena. Joseph Stednick exhibited obvious medical problems. This was not a mistake of inadvertance or an error caused by Dr. Rosi's lack of sleep. The medical problem was too obvious for that to be an excuse. Whether or not the infant would have lived, it is the opinion of the Hearing Officer that Dr. Rosi committed a serious error in judgment in failing to hospitalize this distressed child as soon as possible.

Dr. Rosi offered numerous explanations for not hospitalizing the baby, including the fact

that he felt that the child was brain damaged, and nothing could be done for the meconium aspiration syndrome. (Rosi, Hrg. 210-211). Dr. Rosi felt that, "The treatment for brain damage is essentially supportive" (Rosi, Hrg. 210), but he also stated that he did not decide in his own mind that the child was brain damaged until 4:30 a.m. (Rosi, Hrg. 217). He described the baby as having a "decrebrate cry", but he "was not sure of the significance of it." (Rosi, Hrg. 235). He felt that, "The baby was either going to recover the neurological functions that were failed or wasn't, and there was nothing that you could do about it." (Rosi, Hrg. 236-237) At one point he suggested that the "monotonous, animal-like tone of the baby's cry" might be a larynx problem, but admitted that he really didn't know what it was. (Rosi, Hrg. 237-238) Ultimately, Dr. Rosi admitted that the answers to the questions that even he was considering could only be determined through tests, and the only place to do those tests was in the hospital, one mile away. (Rosi, Hrg. 238-240)

Dr. Rosi's explanations are inadequate, incomplete and erroneous. In his defense, certainly he has agonized over this case as much or more than anyone, and he himself is no doubt groping for explanations. Nonetheless, the issue before the licensing board is whether

or not Dr. Rosi by failing to hospitalize Joseph Stednick has exhibited professional incompetence to the point that the medical board should act on his license. It is the opinion of the Hearing Officer that he has, and it is the opinion of the Hearing Officer that this has been established by clear and convincing evidence.

Dr. Rosi continues to hold the belief that hospitalization would not have made any difference in the outcome of this case. (Rosi, Hrg. 279, 281). Evidently, Dr. Rosi feels that the baby would have died anyway. While this may be true, the logic suggests that the more serious the medical crisis, the less likely Dr. Rosi will be inclined to hospitalize. While this may be a humanitarian way of allowing a family to handle imminent death, the fact of imminent death must be absolutely established before the decision of where the death will occur is made. In this case, if he indeed felt that the death of the infant was imminent, he was premature in reaching that conclusion. If he did not feel death was imminent, he, by his own admission, failed to take the necessary steps to insure that the infant had the best treatment available in order to preserve his life.

REMEDY

In fashioning a remedy for the board to consider in this case, of primary importance is the balance between Dr. Rosi's right to practice medicine and the protection of the public. Because the evidence presented concerned one incident, it is possible that it will never be repeated. Indeed, Dr. Rosi is a caring, compassionate man who should be allowed every opportunity to demonstrate that, in fact, this was an isolated error of medical judgment that was atypical of his competence. For that reason, it is the recommendation of the Hearing Officer that the public interest in insuring that Dr. Rosi is indeed the competent doctor that Dr. Babcock described in his testimony would be best be served by placing Dr. Rosi on probation for eighteen months.

The purpose of the probation is to allow Dr. Rosi to continue to practice medicine, but to have his practice monitored under the supervision of a doctor or doctors licensed in Alaska in the fields of practice in which Dr. Rosi wishes to engage. The supervision should be informal with the supervising doctor or doctors reporting by letter to the Board every three months. The reporting letter should inform the Board that Dr. Rosi has or has not performed in a competent manner. In this way, Dr. Rosi would not be restricted in his

practice, and yet the licensing board can be assured that this instance was a single error that will not be repeated. Should a negative report be submitted, the Medical Board can investigate the cause of the negative report and take whatever steps it deems appropriate.

Dated: January 28, 1981.

ALASKA STATE MEDICAL BOARD

By: /S/ Thomas W. Findley
THOMAS W. FINDLEY
Hearing Officer